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NHS
Gloucestershire Care Services
NHS Trust

Annual Report and Accounts 2018-19

Understanding You

Gloucestershire Care Services NHS Trust
Annual Report and Accounts 2018-19
Presented in accordance with the Department of Health and Social Care Group Manual for Accounts 2018-19

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Annual Report and Accounts 2018-19

About this document

This document fulfils the annual reporting requirements for NHS trusts.

Copies of this document are available from our website at www.glos-care.nhs.uk, as well as by sending an email to the TrustSecretary@glos-care.nhs.uk or by requesting a copy by writing to: Trust Secretary, Gloucestershire Care Services NHS Trust, Edward Jenner Court, 1010 Pioneer Avenue, Gloucestershire Business Park, Brockworth, Gloucester, GL3 4AW.

If you would like this report in a different format – such as large print – or in a different language, please contact the Trust Secretary.

Foreword

Welcome from the Chair

As always it is a pleasure to welcome you to this year's Annual Report, which will describe the key achievements of Gloucestershire Care Services NHS Trust in a year which marks the end of one phase of our development as an organisation and the beginning of new and exciting possibilities.

Plans are now well advanced for the merger of our Trust and 2gether NHS Foundation Trust which provides mental health and learning disabilities services in Gloucestershire and Herefordshire.

The reason for this merger has always been, and continues to be, the conviction that we can better provide integrated physical and mental health services as a single organisation than as separate ones. This is supported by stark evidence of health inequalities, poorer outcomes and shorter life expectancy for people with mental health issues or learning disabilities.

Life expectancy for people with long-term mental health problems is 15 to 20 years shorter than for the general population, while people with long-term physical health conditions are three times as likely to have mental health problems. So there are compelling reasons to bring the organisations together so we can meet the needs of the whole person – any combination of physical, mental and learning disabilities needs – with evidence-based plans for better care.

The possibilities from doing so are really exciting, whether it's improved physical health outcomes for children and young people with learning disabilities, or improved dementia care in our community hospitals. I firmly believe that pooling our expertise and resources gives us an opportunity to plan and deliver significant improvements for the people we serve over the coming years.

Happily, we appear to be in tune with opinion across the NHS as a whole, and with the Government, with the NHS Long Term Plan highlighting the importance of investment in both community health and mental health services. That plan also puts the spotlight on clinical priorities including stroke, diabetes, respiratory health and mental health services, and highlights the need for greater partnerships between professionals and people who use services, and a commitment to increasing support for people to manage their own health.

It's a testament to our clinicians and clinical leadership that we were already preparing for many of the ideas presented in the Long Term Plan. In April 2018, we launched the Complex Care at Home service which offers preventative early intervention to help people with multiple long-term conditions avoid social isolation and develop self-management techniques, mirroring expectations which then came in the Long Term Plan in January.

Foreword

Welcome from the Chair

We've recently opened a new 14-bed stroke rehabilitation unit (in a first for Gloucestershire) at the Vale Hospital to provide the specialist therapy-led care which is now widely recognised as an essential part of recovery after stroke. And we've established Gloucestershire Self-Management, where volunteers with experience of long-term conditions offer peer-led support and tools for self-management to help others.

All of these developments require the support and co-operation of our wider system partners, and we continue to develop and strengthen links as a member of the Gloucestershire Integrated Care System. Further examples of that closer working over the last 12 months include the way community services have been designed alongside groups of GP practices, and ongoing work to join up respiratory care for patients across organisations.

I am very conscious of the demands that maintaining high quality care – and developing new and improved services – while conducting a merger of two large and complex Trusts is placing on my colleagues. We are going through change, which always brings with it uncertainty. We ask a lot, so I'd like to take this opportunity to place on record my gratitude and admiration for the professionalism, dedication and resilience I see from so many people across the Trust every day. I am immensely proud of the way in which colleagues, almost without exception, put their own interests into the background and focus on delivering services. Our colleagues always have our service users and carers as their priority, whatever challenges they are facing in their professional or personal lives.

Amongst my board colleagues I'd like to thank Dr Mike Roberts, who served the Trust as Medical Director for almost five years and whose combination of warmth, humour and judgement were a great asset to the executive team. Mike retired from the Trust on January 31, 2019 to return full-time to his GP duties.

I'd like to welcome Paul Roberts following his first full year as Chief Executive, Dave Smith to his role as Director of Transition (as of July 1, 2018), Neil Savage as Joint Director of Human Resources (July 1, 2018) and most recently Dr Amjad Uppal who has succeeded Mike Roberts to become Joint Medical Director (February 1, 2019) for what is guaranteed to be a rewarding, if challenging, year ahead.

Ingrid Barker
Chair

Performance Report

Chief Executive's Introduction

As Chief Executive of Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust it is my pleasure to present Gloucestershire Care Services' Annual Report for 2018-19.

It has been an especially busy year at the Trust. Not only are we dealing with increased demand for our services – the national NHS picture is one of rising demand due to the increasingly complex needs of an ageing population – but we are undergoing a major organisational transformation at the same time.

So I am proud of the way that my colleagues, working with our partners, continue to meet these challenges. I have been consistently impressed by the quality of care we provide across Gloucestershire, the dedication to seeing people in community settings and their own homes and the appetite to learn and innovate.

Equally, I have been encouraged by the ongoing work of my corporate colleagues – who do a lot of unseen and unsung work with a lot of competing demands, and yet who have taken on the task of planning for our merger with 2gether NHS Foundation Trust with enthusiasm and commitment.

This report will provide evidence of the entire range of our work - the care we are providing, innovation we are leading, and the planning for a future where we offer a combined physical health, mental health and learning disabilities service.

We are, of course, always building on the achievements of previous years. Just 18 months ago the Trust was announcing its CQC rating had improved to Good, which itself was recognition of prior improvements. This strong track record has continued through the past 12 months, with good performance across the Trust – whether you look at our clinical outcomes, or our infection control data or what people say about us when they complete the Friends and Family Test.

The full achievements of the Trust's patient care are detailed in the Quality Account, as well as enhancements to existing services and developments into new areas. I would like to highlight just a few key achievements:

- Completing our CQC 2018 inspection recommendations
- Active contributions to national quality improvement initiatives including the National Audit for Care at End of Life and the Preventing Pressure Ulcer Safety Collaborative
- Introduction of the National Early Warning Scores (NEWS2) across many of our services
- Achieving a 77% flu vaccination rate for frontline colleagues
- NHS Staff Survey results indicating a significant focus on safety culture
- A reduction in grade 3 and 4 pressure ulcers, and in outbreaks of norovirus and influenza

Performance Report

Chief Executive's Introduction

- Seeing and treating 99% of patients in our Minor Injury and Illness Units (they saw a handful less than 78,000 people) within 4 hours
- A significant reduction in delayed discharges from our Community Hospitals
- Our Musculoskeletal Physiotherapy service seeing an additional 1,380 people—equivalent to an extra month's work

Within this report you will also find our annual accounts, providing a comprehensive view of the financial position of the Trust. I am always conscious that the accounts are – to the non-accountants among us – quite a dry and technical document! So, if I can precis them here, it would be to say that the Trust has been in a strong financial position for a number of years and the trend has continued through 2018-19. Within the accounts I would highlight (to follow)::

- The Trust met all its financial targets this year
- We achieved challenging cost improvement targets while delivering a planned surplus of £3.1m
- Our good financial performance earned an additional £2m of Provider Sustainability Funding, resulting in a final surplus of £5.1m

Gloucestershire Care Services was formed in 2013 and – all being well - is nearing the end of the first phase of its development as a community trust and a new future with a broader remit and new opportunities.

However, amidst all the change my colleagues and I remain dedicated to meeting the health needs of the people we serve, reducing health inequalities, improving the quality of services and responding to the different needs of different groups of people. We will have many opportunities in the coming months and years to fulfil these aspirations.

Paul Roberts
Chief Executive

Performance Report

Joint working with [2]gether NHS Foundation Trust

In September 2017, the Boards of Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust announced plans and agreed a strategic intent to work on proposals to integrate the two Trusts into a single organisation.

Since then, the two Trusts have appointed a Joint Chair, Ingrid Barker, who took up her position in January 2018. We have also appointed Paul Roberts as Joint Chief Executive, who started in his post in April 2018, as well as a joint Shadow Board.

We have a vision that within the next five years an older person, living in Gloucestershire or Herefordshire, who is frail and has dementia, will receive care from a single team, co-ordinated by a single professional, co-designed with them and their family and based on expressed personal needs. The same will apply to a person with a learning disability, a vulnerable child or adolescent, a person with a physical disability or with a serious long-term mental illness – indeed to anyone whose life can be enhanced through joined-up care based in their home or local community.

Our proposed merger with 2gether NHS Foundation Trust (2gether), planned for October 1, 2019, will allow us to achieve this vision more quickly and with fewer barriers. Whilst the strategic case for this merger makes good business sense and will accelerate the local achievement of national policy priorities; its foundations are the benefits for people who use our services and the communities whom we serve. It will also assist us in playing a full role in the ICS in Gloucestershire.

Both Trusts are already effective organisations firmly rooted in their strong values. They are both financially healthy and rated 'good' by the Care Quality Commission (CQC). We believe that through a merger the whole can be even greater than the sum of the parts.

Our merger will also assist us to achieve progress on implementing national policy priorities, for example:

- Contributing to the NHS drive towards an equal response to mental and physical health with the ambition of achieving genuine 'parity of esteem' between physical and mental health by 2020
- Supporting our communities with the right (mental health) care at the right time and of the right quality
- Expanding proven community-based services for people of all ages with severe mental health problems who need support to live safely and as close to home as possible
- Working with partners to address suicide and self-harm, local rates of which are above the national average
- Working with partners to ensure those in our communities with a learning disability or autism, can live in their own homes, develop and maintain positive relationships and get the support they need to be healthy, safe and play an active part in society

Joint working with ²gether NHS Foundation Trust

- Supporting our colleagues in General Practice in their national priority of reducing workload by developing community based prevention strategies, addressing co-morbidity and the challenge of those presenting with medically unexplained symptoms and by offering GPs easier referral, more effective multi-disciplinary assessment and less burdensome management of care pathways

Some benefits could be achieved by developing closer working relationships, including through our Integrated Care Systems. However, we believe (partly based on case studies of places and organisations which have already merged) that working as one organisation can make a fundamental difference to, for instance:

- The development of single management and accountability arrangements for integrated care teams
- The deployment of joint operational budgets
- The application of common clinical, operational and human resource policies
- The assurance of quality and safety for our complex service users through one governance system
- The sharing of corporate overhead costs to ensure resources for front-line care are maximised
- The influence of our organisation through our combined size within our ICSs to advocate for our service users and philosophy of integrated, place-based care

We believe our case demonstrates that our merger will also benefit our workforce and our partners, for instance:

- In combination we can offer better opportunities for talent management and workforce development
- We are already exploring the development of joint training facilities
- The development of integrated teams will help to mitigate some of the (national) shortfalls in recruitment which we encounter
- Our colleagues in primary care often ask for more integrated mental and physical health support within or close to practices. We will be in a better position to offer this together
- It is those admitted to hospitals with complex problems who can become “stranded” and the development of better integrated care can help both to reduce admissions and to provide better transfers of care at point of discharge

In summary we strongly believe and we can demonstrate that the creation of a £200m organisation in an NHS world of larger providers will make us more sustainable and that our own integration will support the wider integration being championed through our ICSs.

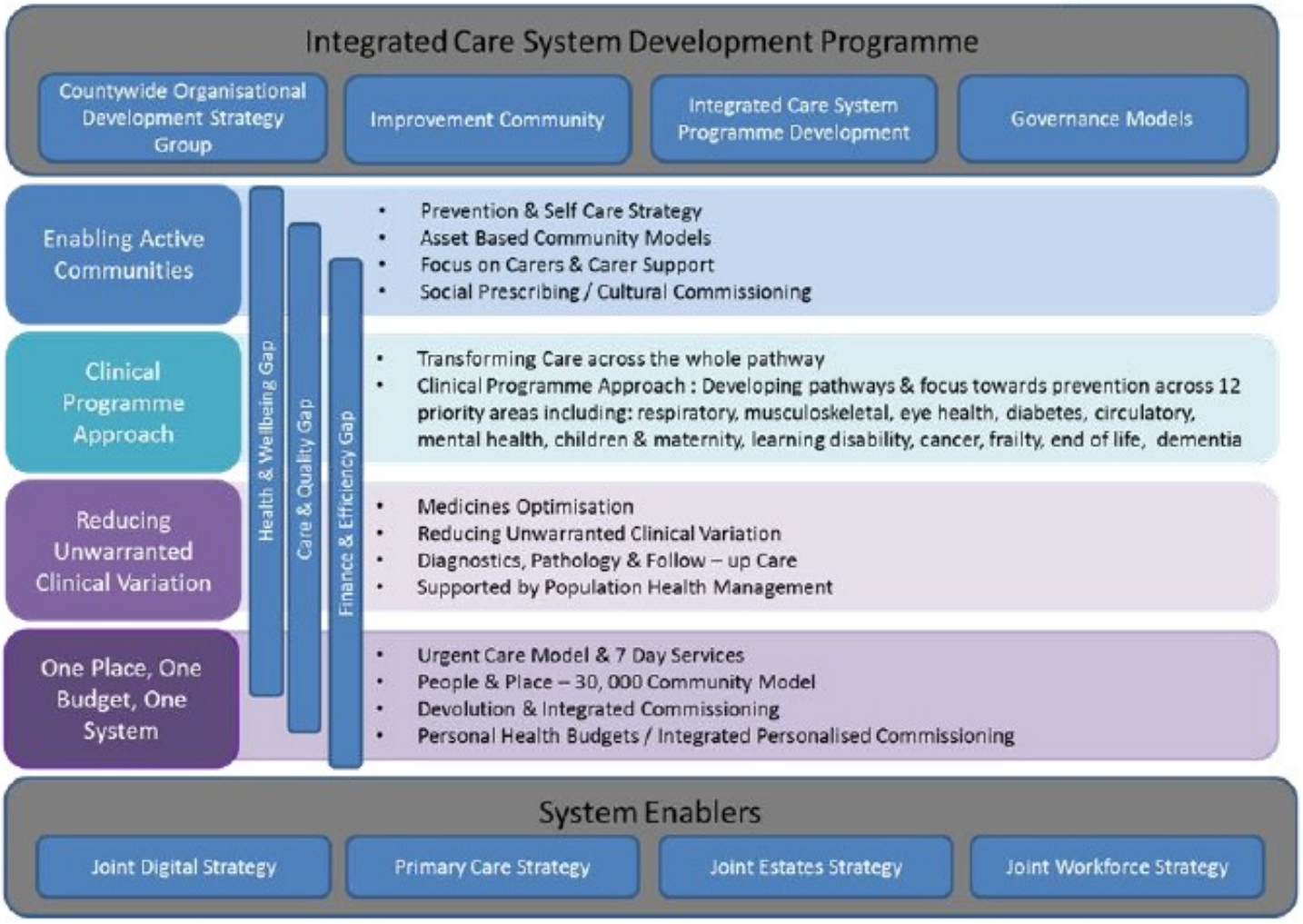
Most importantly we believe that our two strong organisations joining together will enable our teams to deliver better care to, and with, service users and their communities.

Performance Report

One Gloucestershire

As a Trust we are a key partner within the One Gloucestershire Sustainability and Transformation Partnership. Gloucestershire's Sustainability & Transformation Plan commenced year two of four in April 2018.

Since then we have made progress in embedding and delivering key schemes outlined within the plan, as we transition to an Integrated Care System (ICS).



The Enabling Active Communities programme looks to build a new sense of personal responsibility and improved independence for health, supporting community capacity and working with the voluntary and community sector.

A Clinical Programme Approach has been adopted across our local health care system to ensure a collaborative approach to redesigning the way care is delivered in our system.

The Reducing Clinical Variation programme looks to elevate key issues of clinical variation to system level, while the One Place, One Budget, One System programme takes a place based approach to resources and ensures we deliver best value.

Performance Report

Who we are

The purpose of this overview is to provide a summary of the Trust's performance during the year across the full breadth of its operation including operational performance, financial performance, quality performance, staff and service user feedback and compliance with key statutory legislation. The performance review is a key element of our accountability to our community, stakeholders, Department of Health and the public purse.

Gloucestershire Care Services is the main provider of NHS community-based health and care services across Gloucestershire, caring for a population of around 635,000 people. We serve the entirety of Gloucestershire, made up of the large urban communities of Gloucester and Cheltenham, sitting within a largely rural community from the Forest of Dean to the Cotswolds.

To support the people of Gloucestershire, the Trust employs more than 2,700 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support service, administrative and clerical workers.

The Trust's vision, which defines its overarching ambition, is "To be the service people rely on to understand them and organise their care around their lives".

The Trust's CORE values are Caring, Open, Responsible and Effective.

Caring	**1 Acting in the best interests of service users** **2 Respecting and valuing others**
Open	**3 Open in our communication** **4 Connecting with others & working across boundaries**
Responsible	**5 Owning our actions** **6 Professional in attitude**
Effective	**7 Ensuring the best outcomes** **8 Realising your full potential**

Performance Report

What we do

Our main role is to support people's health needs in the most appropriate place in the community.

We work in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices. We also provide in-reach services into acute hospitals, nursing and residential homes and social care settings.

We run the county's seven community hospitals, provide nursing, physiotherapy, reablement and adult social care in community settings, and run health visiting, school nursing and speech and language therapy services for children.

We also provide a number of specialist services including sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability and community equipment.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to, home as possible. To enable this the Trust has made a strategic commitment to place-based working, which means working alongside GP colleagues so that the experience of receiving care from us, or from your GP, is as seamless as possible.

During 2018-19 the Trust was part of the development of Integrated Locality Boards, which in time will become Integrated Locality Partnerships. These are the names being given to the groups of services working with GPs so people experience joined up and responsive services, and better outcomes.

Around 90% of all patient contact with the NHS happens in community or primary care settings - mostly through GP services. Community services are not always as visible to the public but play a vital role in supporting people.

The NHS Long Term Plan has recognised the growing importance of Community Services as the NHS looks to meet the needs of an ageing population with more complex needs and a growing number of people with long-term health conditions such as diabetes and chronic obstructive pulmonary disease (COPD).

Performance Report

What we do

Our services during 2018-19 were:

Countywide and Specialist Services

- Specialist nursing
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Podiatry
- Musculoskeletal Advanced Practioner Service (MSKAPS)
- Wheelchair service
- Sexual health services
- Community dentistry

Children and Young People's Services

- Health visiting
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Community nursing
- Complex care respite service
- School nursing

Community Hospitals

- Inpatient rehabilitation
- Semi-acute care inpatient service
- Outpatient services
- X-ray and diagnostic services
- Minor injury and illness service

Integrated Community Teams

- Community nursing, occupational therapy and physiotherapy working alongside reablement and social work services from Gloucestershire County Council

- These clinical and care services are supported by a range of corporate services, including finance, human resources, clinical quality and governance, information and performance, IT, estates, facilities, risk management, communications, engagement and the service user experience team.

Performance Report

Financial Performance summary

The Trust met all its financial targets in 2018-19, managing to maintain performance while delivering against a challenging cost improvement agenda. The control total was £3.1m surplus, which included £2m of Provider Sustainability Funding (PSF). The Trust met its control total and as a result received additional PSF of £2m. This meant that the Trust ended the year with an NHS basis adjusted surplus of £5.1m against an income of £118.6m. At the end of the financial year the Trust's cash balance was £17.8m.

Sources of Trust Income

	2018-19		2017-18		2016-17	
Source	£m	%	£m	%	£m	%
Gloucestershire Clinical Commissioning Group	94.0	79	92.8	81	95.0	84
NHS England	10.6	9	10.1	9	5.5	5
Gloucestershire Hospitals NHS Foundation Trust	5.9	5	5.8	5	5.5	5
Gloucestershire County Council	1.9	2	2.1	2	2.2	2
Other NHS Commissioners	3.1	3	1.5	1	2.4	2
Other	3.0	3	2.2	2	1.9	2
Total	118.4		114.5		112.5	

Trust Expenditure

	2018-19		2017-18		2016-17	
Service	£m	%	£m	%	£m	%
Community Hospitals (and MIIUs prior to 2018-19)	23.0	20	24.4	22	25.2	23
Integrated Community Teams (ICTs)	17.7	15	17.7	16	18.7	17
Countywide Services	14.4	13	15.1	14	15.1	14
Children & Young People's Services	11.9	10	12.2	11	12.8	12
Support Services	16.1	14	14.0	13	13.1	12
Sexual Health Services	5.9	5	6.5	6	6.7	6
Urgent Care (including MIIUs in 2018-19)	8.2	7	4.7	4	5.0	5
Nursing and Quality	3.8	3	2.7	2	3.0	3
Estates and Facilities	11.2	10	10.5	10	10.2	9
Other Operations	1.7	1	1.2	1	0.8	1
Total	114.0		109.0		110.6	

Performance Report

Financial Performance summary

External Financing

The Trust is given an external financing limit against which it is permitted to underspend

	2018-19	2017-18
	£'000	£'000
Cash flow financing	(5,336)	(4,184)
External financing requirement	**(5,336)**	**(4,184)**
External Financing Limit (EFL)	(1,459)	(802)
Under (over) spend against EFL	**3,877**	**3,346**

Capital Resource Limit

	2018-19	2017-18
	£'000	£'000
Gross Capital Expenditure	5,721	3,335
Less: Disposables	(56)	-
Less: Donated and granted capital additions	(340)	-
Charge against capital resource limit	**5,325**	**3,335**
Capital Resource Limit (CRL)	5,335	3,400
Under (over) spend against CRL	**10**	**65**

Breakeven duty rolling assessment

	2018-19	2017-18
	£'000	£'000
Breakeven duty in-year financial performance	5,069	5,563
Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had	**18,956**	**13,887**
Operating income	118,622	114,545
Cumulative breakeven position as a % of operating income	**16.0%**	**12.1%**

Performance Report

Our Care Quality Commission Rating: Good

We are proud to have an overall rating of GOOD, which was awarded in 2018 and demonstrated considerable improvements since our last comprehensive CQC inspection in June 2015. We believe this reflects the hard work and dedication Trust colleagues have to great quality care and to continuous service improvements.

The CQC also highlighted areas of outstanding practice. The CQCs report included recognition of the Trust's leadership, safe reporting cultures, staff engagement and well established systems of governance that provides assurance that we have a culture of putting patients and quality care first. The table below highlights our CQC results by service and domain.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community dental services Sept 2015	Good	Good	Good	Requires improvement	Good	Good
Community end of life care Apr 2018	Good	Requires improvement	Good	Good	Good	Good
Community health inpatient services Apr 2018 (safe) Sept 2015 (others)	Requires improvement	Good	Outstanding	Good	Good	Good
Community health services for adults Apr 2018	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families Sept 2015	Good	Good	Good	Good	Good	Good
Sexual health services Sept 2015	Good	Good	Good	Requires improvement	Good	Good
Urgent care services Apr 2018	Good	Good	Good	Good	Good	Good
Overall Apr 2018	Good	Good	Good	Requires improvement	Good	Good

Performance Report

Care Quality Commission rating: Well-Led

CQC Assessed the Trust well-led as good for a breadth of reasons including:

- The Trust had an experienced executive and non-executive director and senior leadership team with the skills, abilities, and commitment to lead the delivery of high-quality services
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to ensure staff at all levels understood them in relation to their daily roles
- The Trust involved clinicians, patients and groups from the local community in the development of the strategy and work with the local mental health trust
- Non-executive directors visited all parts of the Trust on a three-monthly basis and fed back to the board to discuss issues staff faced and challenged directors appropriately
- There was evidence of high levels of respect between staff and passionate and knowledgeable managers who motivated their staff and made them feel valued

CQC recommendations

The Trust's CQC report included a Quality Improvement Plan with a number of 'must-do' recommendations. We have met all of these recommendations – details of actions taken across the Trust, including a review of our 2018-19 Quality Priorities, can be found in the Quality Account.

Performance Analysis

Our Delivery Performance

In 2018-19 the Trust had just under 1.2 million contacts with service users, an average of around 3,230 each day.

We have maintained a strong track record of delivering against our national and local targets throughout 2018-19. The Trust fully achieved 80% of national targets and 63% of local targets, and significantly achieved a further 10% (national) and 16% (local).

	National	Local
Total number of targets	**10**	**38**
Achieved fully	**8**	**24**
Achieved significantly	**1**	**6**

We monitor our activity against a range of indicators – including national, local and contractual targets – to help ensure we deliver high-quality services. Our performance data against a range of metrics is set out over the following pages.

CQC Domain: Are Services Caring?

	Metric	Reporting Level	Threshold	2018-19	2017-18	2016-17
1	Friends and Family Test Response Rate	National	15%	14.5%	8.3%	4.3%
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	Local	95%	92.7%	92.4%	95.2%

The Trust's promotion of the Friends and Family Test[1] has been effective in increasing response rates, which have more than tripled over the last two years, and have been rising steadily since July 2018.

In the last few months the Trust has targeted additional effort at increasing response rates within Minor Injury and Illness Units, and from Children's Services.

Recommendations from respondents[2] are slightly improved from last year.

Performance Analysis

Our Delivery Performance

CQC Domain: Are Services Safe?

	Metric	Reporting Level	Threshold	2018-19	2017-18	2016-17
3	Number of post-48 hour Clostridium Difficile infections	Local	18	15	16	13
4	Number of MRSA bacteraemias	Local	0	0	0	1
5	VTE risk assessment: % of patients with assessment completed	National	95%	96.9%	95.0%	96.4%
6	Safety Thermometer: % harm free	Local	95%	93.7%	94.1%	98.0%

The Trust has seen excellent performance against infection control targets, with no cases of MRSA and the number of C-Difficile infections within target.

Assessments for Venous Thomboembelism (VTE) remain on or above the 95% target for the third consecutive year.

Harm free care[6] is measured via the Safety Thermometer score which surveys a sample of patients each month in four key areas. This remains in line with last year, although still outside target. Pressure ulcers are the main cause of harm, and our clinical governance team is supporting operational colleagues with training and incident learning to improve performance.

CQC Domain: Are Services Effective? Community Hospitals

	Metric	Reporting Level	Threshold	2018-19	2017-18	2016-17
7	Bed Occupancy: Community Hospitals	Local	92%	93.6%	96.7%	98.5%
8	Bed days lost due to delayed discharges as percentage of total bed days	Local	< 3.5%	1.4%	5.9%	3.9%
9	Percentage of patients waiting less than six weeks from referral for a diagnostic test	National	> 99%	100%	100%	100%

Bed occupancy[(3)] remains slightly higher than threshold, but has been reduced year on year since 2016-17. We have recently reviewed the evidence around bed occupancy in community hospitals and conducted an internal audit that our current occupancy levels are safe.

We have improved bed days lost due to delayed discharges through improved patient flow through our hospitals. This has been achieved thanks to better patient reviews, clearer patient plans and an improved discharge process.

Performance Analysis

Our Delivery Performance

CQC Domain: Are Services Responsive?				Minor Injury and Illness Units		
	Metric	Reporting Level	Threshold	2018-19	2017-18	2016-17
10	MIIU: % seen and discharged within four hours	National	95%	99.0%	99.3%	99.6%
11	Total time spent in MIIU less than four hours (95th percentile)	Local	< 4 hours	02:58	02:53	02:35
12	MIIU: Time to treatment in department (median)	Local	< 60 mins	00:34	00:26	00:16
13	MIIU: Unplanned re-attendance within seven days	Local	< 5%	0.9%	2.4%	3.4%
14	MIIU: % of patients who left department without being seen	Local	<5%	3.9%	3.4%	1.6%
15	Time to initial assessment for patients arriving by ambulance (95th percentile)	National	< 15 mins	00:20	00:18	00:22
16	Trolley waits in the MIIU must not be longer than 12 hours	National	< 12 hours	0	0	0

The performance of the Minor Injury and Illness Units has been very strong, with six of seven targets reached. Our Time to Initial Assessment for patients arriving by ambulance[15] is a small sample, which is reflected in the variability of the results.

We reached 17 out of 25 (68%) of our referral to treatment targets (next page) as we had done the previous year. Vacancies and staff turnover have impacted capacity in Adult Speech and Language Therapy[17] service. We have established temporary and locum cover while recruitment takes place, to support an improvement in performance. We also developed a new community service model to ensure we balance the priorities of care in acute and community settings.

Our MSK Physiotherapy[19] service has seen 1,380 more people this year than last, equivalent to an entire extra month of activity. We are working with commissioners on measures to meet this increased demand.

We have been conducting capacity modelling for ICT Physiotherapy[26] and ICT Occupational Therapy[27] on a locality by locality basis, so we can be confident we are offering equitable access to these services across the county.

Currently, patients with urgent needs can choose appointments with the MSKAPS[36] service outside of two weeks. As a result, this metric has been suspended from April 2019 in agreement with commissioners pending further discussion on how to resolve this issue.

There are no capacity issues within the Stroke ESD[37] service, but there was a glitch in how data was performance data was being captured. We have corrected this and the services has been offering assessment within two days of notification for 100% of patients over the last six months.

Performance Analysis

Our Delivery Performance

CQC Domain: Are Services Responsive? (contd)						Referral to Treatment
	Metric	Reporting Level	Threshold	2018-19	2017-18	2016-17
17	Speech and Language Therapy: % treated within eight weeks	Local	95%	55.8%	84.4%	95.8%
18	Podiatry: % treated within eight weeks	Local	95%	97.2%	92.8%	94.3%
19	MSK Physiotherapy: % treated within eight weeks	Local	95%	89.7%	90.7%	93.1%
20	Diabetes nursing: % treated within eight weeks	Local	95%	93.5%	96.2%	98.6%
21	Bone Health: % treated within eight weeks	Local	95%	99.1%	99.5%	99.7%
22	Contraception service and Sexual Health: % treated within eight weeks	Local	95%	99.9%	100%	99.7%
23	HIV service: % treated within eight weeks	Local	95%	100%	100%	100%
24	Psychosexual service: % treated within eight weeks	Local	95%	100%	100%	100%
25	Sexual Health: % of terminations carried out within nine weeks and six days of gestation	Local	70%	77.6%	77.4%	81.5%
26	ICT Physiotherapy: % treated within eight weeks	Local	95%	82.8%	85.0%	87.7%
27	Occupational Therapy: % treated within eight weeks	Local	95%	75.5%	82.8%	91.3%
28	Paediatric Speech and Language Therapy: % treated within eight weeks	Local	95%	97.5%	97.7%	97.4%
29	Paediatric Physiotherapy: % treated within eight weeks	Local	95%	91.9%	99.0%	95.6%
30	Paediatric Occupational Therapy: % treated within eight weeks	Local	95%	95.7%	96.6%	96.8%
31	MSKAPS service: % treated within eight weeks	Local	95%	96.5%	57.1%	85.8%
32	Newborn Hearing Screening coverage	National	97%	100% (end Q1)	100%	100%
33	Newborn Hearing Screening completed by five weeks (community sites): Well Babies	National	97%	99.9% (end Q1)	99.6%	99.5%
34	MSKAPS service: % of referrals referred on to secondary care	Local	< 30%	15.9%	12.4%	12.2%
35	MSKAPS service: patients referred to secondary care within 2 days of decision to refer onwards	Local	100%	100%	100%	100%
36	MSKAPS service: wait to referral for urgent patients to be seen not to exceed two weeks	Local	95%	49.5%	95.9%	98.5%
37	Stroke ESD: % of new patients assessed within two days of notification	Local	95%	84.3%	88.6%	96.7%
38	Stroke ESD: % of patients discharged within six weeks	Local	95%	97.0%	98.9%	99.5%
39	SPCA: % of calls abandoned	Local	< 5%	1.4%	2.7%	5.7%
40	95% of priority 1 & 2 calls anwered within 60 seconds after introductory message finishing	Local	95%	97.2%	90.5%	83.4%
41	Rapid Response: number of referrals	Local	3692	3,905	3,726	2,993
						Cancelled operations
42	No urgent operation should be cancelled for a second time	National	0	0	0	0
43	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	National	0	0	0	0

Performance Analysis

Our Delivery Performance

CQC Domain: Are Services Well-Led?						
	Metric	**Reporting Level**	**Threshold**	**2018-19**	**2017-18**	**2016-17**
44	Staff Friends and Family Test: % of staff who would recommend the Trust as a place of work	Local	61%	58.5%	53.3%	51.8%
45	Staff Friends and Family Test: % of staff who would recommend the Trust as a place to Receive treatment	Local	67%	84.6%	83.0%	80.3%
46	Mandatory training	Local	92%	85.9%	82.6%	77.8%
47	% of staff with completed Personal Development Reviews (appraisal)	Local	95%	77.1%	79.9%	75.0%
48	Sickness absence: average % rolling rate over 12 months	Local	< 4%	4.8%	4.6%	4.4%

Recommendation of the Trust as a place to work has risen year-on-year since 2016-17 and increased by over 5% in the last year. Recommendations as a place to receive treatment have also been improving over the same period.

Mandatory training has also improved year on year but remains below the threshold. Training leads are working to identify and address teams where compliance is low, and have developed a program of facilitated e-learning as well as expanding the range of venues for moving and handling training.

Completion of personal development reviews and sickness absence remain areas where the trends are not positive. Processes are being revised to improve completion of PDRs and management of sickness absence.

The Trust's HR team has reviewed the policy and guidance on sickness management, and the Trust is promoting a health and wellbeing agenda to promote healthy lifestyles amongst colleagues, with more than 400 regular participants in Health & Hustle activities and competitions.

A Note on Red / Amber / Green (RAG) Ratings

The Trust recognises that coloured RAG ratings do not always provide a complete picture of data and is exploring the use of trajectories to better illustrate changes, patterns and context. This will be taken forward within the proposed merged Trust, building on current experience and national good practice.

Performance Analysis

Quality and Sustainability

The Trust Quality Account provides a detailed overview of the work progressed in 2018-19 to improve quality. The Trust is also mindful of its role in supporting sustainability.

Quality

During 2018-19 we set quality priorities to improve performance in:

- Meeting the needs of service users in relation to pressure ulcers, equalities, dementia, falls and end of life care;
- Improving health and well-being for colleagues

Progress against these is tracked in detail in our Quality Account, published separately on our website.

Sustainability

In 2018-19 the Trust maintained activity to support environmental sustainability with ongoing work to reduce water usage, energy consumption and waste to landfill.

The Trust has completed its programme of renewable energy at its community hospitals and now has in place solar photovoltaic panels at six out of seven of its community hospitals. These benefit the Trust financially through energy savings and the Feed in Tariff and ensure that all these hospitals have some of their energy demands supplied through renewable energy.

There has been significant investment in low-energy LED lighting systems at the community hospitals in the North Cotswolds, Vale and Tewkesbury. All three have been classified as excellent using BREEAM, a recognised sustainability assessment method for buildings and infrastructure.

Similar lighting systems have also been installed during refurbishment of one of the wards at Stroud Hospital (Cashes Green Ward) and during the refit of Sourthgate Moorings, which is now a significant base in Gloucester for clinical teams.

The Trust's head office is based in an open plan model building, Edward Jenner Court. The building is controlled by a building management system and lighting is automated. The building management system has been optimised to minimise the run time of the air handling systems to reduce electricity consumption.

The Trust is in the fourth year of the implementation of its new waste policy which means more waste is recycled and less is sent for incineration. Recycling awareness is promoted

through waste posters which are disseminated throughput and the dissemination of recycling bins.

The Trust has smart screens available in its main meeting rooms and supports staff to use technology such as laptops and mobile devices to reduce printing, for example through setting printers to double sided and black and white copying.

The Trust has in place electronic health records management systems which also reduce printing requirements and use of paper. These measures together have contributed to a reduction of stationery costs by more than 60% over three years.

The Trust's Community Hospitals provide in- and out-patient services to enable patients to be seen closer to home, reducing travel and carbon emissions.

The Trust has in place schemes to promote green travel including car sharing schemes (10% of spaces at head office reserved for car sharing), bicycle use schemes for staff and provision of IT equipment to support mobile working to reduce unnecessary mileage.

The Trust's Estates Team ensures that obligations under the Climate Change Act and Adaptation Reporting requirements are complied with, and is working with system partners to develop joint sustainability plans.

The Trust achieved Mindful Employer status in 2017-18 and during 2018-19 has worked to embed a range of initiatives including mindfulness training and Health & Hustle activities which encourage health and well-being. Over 400 staff now take part in these activities, an increase of more than 250 over the last 12 months.

The Trust continues to increase its number of volunteers, with almost 400 volunteers now in place across the Trust supporting service users in a wide variety of ways.

Human Rights, Anti-corruption and Anti-Bribery

As is set out in the Annual Governance Statement later in this report the Trust has in place the processes to ensure its social commitments, including respect for human rights, anti-corruption and anti-bribery, are met.

Performance Analysis

Patient Experience

Friends and Family Test (FFT)

We are constantly looking at opportunities to improve the experience of service users and carers. We are pleased that over 92% of service users who responded to the Friends and Family Test would be likely or very likely to recommend our services, at a time when the number of respondents to our surveys is growing rapidly.

We have continued to revise the style of questionnaire and increased its service specificity to improve the quality of feedback, ensuring that the views of our service users drive our services and are at the heart of how we operate.

Service	2018-19	2017-18	2016-17
MIIU response 'likely' or 'very likely' to recommend	93.0%	94.4%	95.9%
Inpatients response 'likely' or 'very likely' to recommend	95.9%	95.0%	96.4%
Children & Young People response 'likely' or 'very likely' to recommend	85.9%	92.3%	96.7%
Integrated Community Teams response 'likely' or 'very likely' to recommend	97.8%	97.5%	97.4%
Countywide and Specialist Nursing response 'likely' or 'very likely' to recommend	94.8%	95.1%	94.4%
Capacity Service 'likely' or 'very likely' to recommend	98.5%	99.2%	96.2%
Overall Response 'likely' or 'very likely' to recommend	92.7%	94.2%	95.2%

Complaints, Compliments, Concerns

Compliments have increased by 43% since last year, and by more than 250% since 2016-17. The number of complaints has fallen from 2 years ago, in line with last year. Concerns are up 24% over the last 12 months.

Feedback Categories	2018-19	2017-18	2016-17
Number of Compliments	1,317	924	512
Number of Complaints	42	44	73
Number of Concerns	485	391	403

Performance Analysis

Supporting Colleagues

We want the Trust to be a great place to work for all colleagues and to support them to achieve their aspirations and goals. We know that everyone is working under increasing pressure and want to do everything we can to help people manage their work life balance.

Staff Engagement

The NHS Staff Survey gives our staff a chance to have their say about our working life in the NHS. It seeks views on areas such as job satisfaction and wellbeing, training and development, health and safety and health and wellbeing.

The results of the survey, which took place between October and December 2018, were published nationally in March 2019 and can be found online at:

www.nhsstaffsurveys.com/Page/1073/Latest-Results/Community-Trusts/

The survey covers 10 themes made up of groups of questions, with historical data back to 2014, where possible. Data in the report is weighted for fair comparisons between organisations.

The 10 themes are
- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying and harassment
- Safe environment – Violence
- Safety Culture
- Staff engagement

Key results
- Compared to last year, two of the themes have shown significant statistical improvements - 'Safety culture' and 'Staff engagement'
- Encouragingly the other 8 themes have remained stable
- Equality, diversity and inclusion comes close to the best
- Overall the Trust is the same as the benchmarking group average in five out of the ten themes. The other five are only slightly worse
- 'Immediate managers', 'Morale', 'Quality of appraisals', 'Quality of care' and 'Safe environment – Bullying and harassment' are in most need of improvement
- These results will need further analysis over the coming months to unpick and understand the distinctions and nuances

Performance Analysis

Supporting Colleagues

Key statistics

- Recommending the Trust as a place to work has increased from 51% in 2017 to 55.8% in 2018. (Below the average benchmarking score of 59.4%)
- If a friend or relative needed treatment, respondents being happy with the standard of care provided by the Trust has increased from 73% in 2017 to 76% in 2018. (Above the average benchmarking score of 74.8%)

Safety Culture

Many of the Trust's staff survey scores represented an improved safety culture among colleagues. Improvements include:

+9.6% We are given feedback about changes made in response to reported errors, near misses and incidents (52.7% up from 43.1% in 2017)

+9.4% My organisation treats staff who are involved in an error, near miss or incident fairly (59.9% up from 50.5% in 2017)

+7.8% I would feel secure raising concerns about unsafe clinical practice (75.8% up from 68.0% in 2017)

+7.6% I am confident that the organisation would address my concern (61.7% up from 54.1% in 2017)

+5.7% When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (67.4% up from 61.7% in 2017)

+3.5% My organisation acts on concerns raised by patients or service users (73.7% up from 70.2% in 2017)

Investors in People (IIP) accreditation

The Trust was assessed against the IIP framework in February 2017. The balance of evidence from the online assessments, face-to-face interviews, documentary evidence and observation produced a final outcome which confirmed that the Trust meets all of the requirements for accreditation as an Investor in People.

The report stated 'This is a very significant achievement, especially in light of the government imposed cost reduction targets, and the size and spread of the Trust and the diversity of services it provides.' It was also highlighted that 'The Trust continues to work in line with its values and in this aspect practice is not only Advanced but very close to High Performing.'

The Trust continues to work to ensure it maintains the ambitions and aspirations achieved within the standard.

Paul Roberts .....Chief Executive (Paul Roberts) May 23, 2019 .....Date

Accountability Report

The Directors' Report 2018-19

The Trust's Board of Executive and Non-Executive Directors is responsible for overseeing the developments of strategic direction and compliance with all governance, probity and assurance requirements.

Details of the Trust's Chair, Chief Executive, Executive Directors and Non-Executive Directors are set out later in the Annex to the Annual Governance Statement, together with information on attendance at the Trust's board and its sub-committees.

Compliance Statement

A register of Directors' interests for the Trust is maintained and is available on the Trust's website or by request from the Trust Secretariat by contacting:
TrustSecretary@glos-care.nhs.uk

The Trust has undertaken the necessary action to evidence that each Director has stated that, as far as they are aware, there is no relevant audit information of which the Trust's Auditors are unaware and they have taken all the steps that they ought to have taken as a Director, in order to make themselves aware of any relevant audit information, and to establish that the Trust's Auditors are aware of that information.

Accountability Report

The Trust as a Going Concern

In preparation of the year end accounts the Directors are required to undertake an assessment as to whether the Trust will continue as a going concern.

As noted within the annual report (see p8-9), the Gloucestershire Care Services NHS Trust (GCS) is due to be acquired by 2gether NHS Foundation Trust on 30 September 2019. Whilst GCS as an entity will cease to operate on the conclusion of the transaction, the services currently provided by GCS will continue within the new entity, which will receive the relevant funding going forward.

Therefore, in accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services is the key consideration when assessing if the accounts should be prepared on a going concern basis.

Through considering the factors noted above and relevant accounting standards, the Directors have confirmed that as the service will continue to be delivered for the foreseeable future and therefore the accounts have been prepared under a going concern basis as set out in IAS 1.

Accountability Report

Annual Governance Statement

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gloucestershire Care Services NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gloucestershire Care Services NHS Trust for the year ended March 31, 2019 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Trust has a risk management strategy, which makes it clear that managing risk is a key responsibility for the Trust and all staff employed by it. The Board receives regular reports that detail risk, financial, quality and performance issues and, where required, the action being taken to reduce identified high-level risks.

Full details of the Trust's approach to risk management is contained in our Risk Management Strategy.

Guidance and training are provided to staff through specific risk management training, wider management training, policies and procedures, information on the Trust's intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents. Information from a variety of sources is considered in a holistic manner to provide learning and inform changes to practice that would improve patient safety, and overall experience of using the Trust's services. During 2018-19 the Trust continued to embed its Risk Steering Group to promote integrated working and enable cross organisational review of risks and consideration of good practice learning.

Accountability Report

Annual Governance Statement

The Risk and Control Framework

The Risk Management Strategy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled.

It identifies strategic and operational risk and how both should be identified, recorded and escalated and highlights the open and honest approach the Board expects with regard to risk. The Trust's risk assessment policy describes the process for standardised assessment of risk including assessment of likelihood and consequence. During 2018-19 the Trust further embedded the use of patient safety software, which was already in use for incident reporting, in its risk management processes; supporting consistency and increased timeliness of organisation wide oversight of risks.

The Board has identified the risks to the achievement of the Trust's objectives and determined the appropriate level of risk appetite. The nominated lead for each risk has identified and evaluated existing controls and sources of assurance that these controls operate effectively. Any gaps in controls have been identified and action plans put in place to strengthen controls where appropriate. The outcome of this process is articulated in the Board Assurance Framework (BAF) and this is presented to the Board for review and endorsement at each routine Board meeting. In line with the Trust's risk management strategy, risks rated 12 or above (8 where there is patient safety/clinical risk identified) are escalated to the Board through the Board's Committee structure. All corporate risks are reviewed regularly by identified Board sub-committees and an escalation process is in place, as outlined in the risk management strategy.

Risk is assessed at all levels in the organisation from individual members of staff within service areas to the Board. This ensures that both strategic and operational risks are identified and addressed.

The Trust has in place a BAF, which sets out the principal risks to delivery of the Trust's strategic objectives. Executive Directors review the risk register and enter strategic risks onto the corporate risk register. In addition, other corporate risks scoring 12 or above (8 where there is patient safety/clinical risk identified), that have been reviewed by the relevant sub-committee, are escalated in line with the Trust's escalations processes.

The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF identifies the key controls in place to manage each of the principal risks and explains how the Board is assured that those controls are in place and operating effectively. These include the monthly performance report, monthly finance report, minutes of the sub committees and assurances provided through the work of internal and external audit, the CQC and the NHS Resolution.

Accountability Report

Annual Governance Statement

Specific areas of risk such as fraud, corruption and bribery are addressed through specific policies and procedures and regular reports made to the Board via the Audit and Risk Assurance Committee.

Proposed Merger with 2gether NHS Foundation Trust

During the year the Trust progressed its proposed merger with 2gether NHS Foundation Trust. Arrangements have been put in place to manage the risks associated with this process which is being conducted with support from NHS Improvement and in line with NHS I's transaction guidance. These risk management arrangements include a robust governance regime led by non-executive directors, the recruitment of additional programme management capacity, and a programme management approach across three work streams coving the merger transaction, the transition process, and the subsequent transformation of services.

Following initial agreement by the GCS NHS Trust Board and 2gether NHS Foundation Trust Board and their Council of Governors in 2017-18, the Trust has progressed its strategic objective to combine the physical health services provided by our Trust with 2gether NHS Trust's mental health and learning disability services through a process of merger by acquisition by 2gether NHS Foundation Trust under the terms of section 56A of the Health and Social Care Act 2012.

Actions have been put in place to mitigate the risks associated with this merger. Both Boards and the 2gether Council of Governors have been fully involved in the decision to proceed with the proposal to merge, and in a robust system of governance for the project. A Strategic Intent Leadership Group (SILG) and a Programme Management Executive (PME), have been put in place that provide the appropriate forums for these risks to be documented and discussed and solutions scoped and agreed.

The PME is responsible for maintaining the Joint Strategic Intent Programme Risk Register and the SILG provides an oversight role, which is executed via the inclusions of risk management as a standing agenda item within the strategic groups' meetings. The SILG has monitored the ongoing progress of the programme against the resource plan and costs so that any deviation is identified and corrective measures can be taken at the earliest opportunity.

A comprehensive communications process is in place to support internal and external briefing to staff and system partners who are able to raise via the PME any concerns that may need to be addressed. The merger is being undertaken in accordance with the requirements of the latest transaction guidance issued by NHS Improvement. An internal audit review of these merger corporate governance and risk management arrangements, published in April 2018, produced an overall classification of low risk.

Accountability Report

Annual Governance Statement

A Programme Director and an administrator were recruited to drive this process forward and to minimise the capacity impact on both Trusts. We have made an allowance within our 2018-19 financial forecasts to fund these costs, and mitigate any potential impact on the financial position. Executive leads are in place for the Transaction, Transition and Transformation elements of the merger process to provide leadership and challenge, particularly in respect of the development of the strategic case, full business case, and post-transaction implementation plan. A project team is in place to manage the transition process, through a series of work streams. In line with NHSI guidance, a thorough due diligence process has been undertaken, and the Audit and Risk Assurance Committee has reviewed and was satisfied with the findings of those due diligence exercises. An Internal Audit review of transaction governance produced a low risk classification.

The Shadow Board for the new Trust was appointed between December 2018 and January 2019, and has assumed the oversight role hitherto undertaken by SILG. The Shadow Board comprises experienced Executive and Non-Executive Directors from both Trusts who will be able to ensure that capacity, capability and organisational memory are retained, and thus to provide strong oversight and direction to the new Trust.

The Governance Framework of the Organisation

The Department of Health (2006) defined integrated governance as: 'Systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations.'

The structures, systems, processes and behaviours NHS bodies are expected to have for ensuring good governance include:

- Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation.
- Requirement for a statutory board, and requirements on the committees that support the board.
- How line managers operate, including codes of conduct and accountability.
- Business planning.
- Procedural guidance for staff.
- Risk register and assurance framework.
- Internal audit.
- Scrutiny by external assessors including the Care Quality Commission, external audit and NHS Improvement.

As Accountable Officer I can confirm that these structures, systems, processes and behaviours are reflected in the Trust's Governance Framework.

Accountability Report

Annual Governance Statement

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Trust and best practice.

The Board Structure and Remit

Gloucestershire Care Services NHS Trust (GCS) is run by a unitary Board of Directors, with clear division of responsibilities between the Chair of the Board and the Chief Executive of the Trust, Non-Executive Directors and the Executive, including appropriate challenge on strategic development. The Board consists of the Chair, six Non-Executive Directors, and five voting Executive Directors. There are also two non-voting Directors (Joint Director of Human Resources and Organisational Development and Director of Transition). Non-Executive Directors use their skills and experience gained from the private, public and voluntary sectors to help run the Trust, but do not have day-to-day managerial responsibilities within the Trust. Executive Directors are paid employees with clear areas of work responsibility within the Trust.

The Board regularly meets in public, and details of the board meetings, including the public papers, are available on the Trust website (www.glos-care.nhs.uk). The Board held seven formal board meetings in 2018-19 and has met a further seven times in private.

The Board is responsible for the leadership, management and governance of the organisation and setting the strategic direction and supporting the development of organisational culture. Its meetings cover comprehensive items on quality, finance and strategy. At each routine Board meeting held in public it considers the Board Assurance Framework, Quality and Finance.

The Board continually self-assesses its performance, evaluating its meetings and those of its committees at the conclusion of business. Further Board discussions have led to a board development programme supported by an external governance advisor. This has helped support effective integration of new Board members into Board working and supported a review of Committee roles and responsibilities to maintain focus. Internal Audit provided assurance on the governance processes in place.

Changes in Board Composition

There were the following changes in the composition of the board in the year:
Katie Norton, Chief Executive, stepped down on April 15, 2018 with the appointment of Paul Roberts as joint Chief Executive of Gloucestershire Care Services and 2gether NHS

Accountability Report

Annual Governance Statement

Foundation Trust. We thank Katie Norton for her contribution to our development.

Mike Roberts, Medical Director, stepped down on January 31, 2019.

David Smith, Director of Human Resources and Oorganisational Development moved to the post of Director of Transition from July 1, 2018 and Neil Savage was appointed as Interim Director of Human Resources and Workforce from July 1, 2018. Dr Amjad Uppal was appointed Medical Director on Feb 1, 2019.

Board Committees

The Board is supported in its work by a number of sub-committees which include:
- **Audit and Risk Assurance Committee** (renamed from Audit and Assurance Committee in September 2018 with revised remit), chaired by Non-Executive Director, Richard Cryer
- **Charitable Funds Committee**, chaired by Non-Executive Director, Nicola Strother Smith.
- **Resources Committee**, chaired by Non-Executive Director, Graham Russell (new Committee replacing Finance and Workforce and Organisational Development Committee from October 2018).
- **Quality and Performance Committee**, chaired by Non-Executive Director, Susan Mead (until August) and Nicola Strother Smith (from October).
- **Remuneration and Terms of Service Committee**, chaired by Trust Chair, Ingrid Barker.
- **Workforce and Organisational Development Committee**, chaired by Non-Executive Director, Nicola Strother Smith (replaced in year by Resources Committee as detailed above).
- **Finance Committee**, chaired by Non-Executive Director, Graham Russell (replaced in year by Resources Committee as detailed above).

Each of the sub-committees reported directly to the Trust Board and:
- Monitored risk relating to their area of responsibility, ensuring the Board had a clear overarching understanding of the risks;
- Provided regular summary reports to the Board on their work for assurance and performance purposes.

Executive Directors are responsible for maintaining effective systems of control on a day-to-day basis. A full governance rationale has been developed providing terms of reference and escalation processes for all sub-committees and the Board, together with standing items, which are in turn encapsulated into programmes of business for each sub-committee and for the Board.

The table shown at Annex 1 of this Governance Statement sets out attendance levels by Executive and Non-Executive Directors at Trust Board meetings and at all sub-committees of the Board.

Accountability Report

Annual Governance Statement

In addition the Trust Board is supported by the Your Care Your Opinion group which provides opportunities for two-way communication with service users and local communities. This enables the Board to benefit from the insight and experience of local people in the planning and delivery of services. During 2018-19 this has included sessions on the Board's developing Strategic Intent with 2gether NHS Foundation Trust, Quality Dashboards and Communication. This year this group has been used to enable service users to contribute to the co-production of the values of the proposed merged organisation.

Audit and Risk Assurance Committee

- Met six times in 2018-19

The Audit and Risk Assurance Committee is constituted in accordance with the provisions of the NHS Audit Committee Handbook 2014.

In September 2018 Board agreed the following revision to the Committee's remit and name: *The Board approved the proposal to amend the Audit and Assurance Committee's Terms of Reference to incorporate review of the Board Assurance Framework and wider assurance relating to risk across the Committee structure and to update the Committee's name to Audit and Risk Assurance Committee.*

The Committee is responsible for providing assurance to the Board that an effective system of integrated governance, risk management and internal control, is in place across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. It has also overseen the audit of the 2017/18 accounts.

As part of these processes the Committee reviewed all reports from completed internal audit assignments for the 2018-19 work plan, which had been agreed by the Committee at the start of the year. The following table summarises the outcomes from those assignments:

Internal Audits 2018-19	Report Classification
Financial Budgeting and Monitoring	Low Risk
Phase 2 BIRTIE (Business Intelligence)	Medium Risk
Human Resources (Recruitment and Induction)	Medium Risk
Estates and Facilities	Medium Risk
CQC Action Plan and Well-Led Review	Low Risk
Information Governance and Legal GDPR	Medium Risk
Information and Performance: Place-based reporting	Advisory

Accountability Report

Annual Governance Statement

Progress against recommendation actions is actively monitored by the Committee and the Internal Auditors have confirmed that actions are being completed within required timescales. The Audit and Risk Assurance Committee has not identified any significant issues in the year 2018-19.

Charitable Funds Committee

- Met twice during 2018-19

Gloucestershire Care Services NHS Trust is the corporate trustee for charitable funds. The Board, on behalf of the Trust, is responsible for the effective overall management of charitable funds. The role of the committee is to oversee the management, investment and disbursement of charitable funds, as delegated, within the regulations provided by the Charities Commission and to ensure compliance with the laws governing NHS charitable funds and the wishes of the donors. The charitable funds seek to provide benefit to local service users and Trust colleagues.

Remuneration and Terms of Service Committee

- Met eight times in 2018-19

The Committee is responsible for supporting the Board to ensure fairness, equity and consistency in remuneration practices on behalf of the Trust Board. The Committee oversees the remuneration, allowances and other terms and conditions of office of the Trust's Very Senior Managers (VSM).

Quality and Performance Committee

- Met six times during 2018-19

The Committee is responsible for providing clear assurance on all issues relating to clinical and professional care, clinical systems, clinical risk management and all prevailing regulatory standards relating to quality and safety. The Committee also reviews the Trust's service delivery activities and agrees and monitors action plans where remedial steps were considered necessary. During the year the Committee considered a range of key issues including clinical audit, safeguarding, end of life care, information governance, patient reported outcomes, research, incidents, complaints and performance.

Resources Committee

- Met three times during 2018-19

The Resources Committee was established with effect from 30th October. This Committee subsumed the Workforce and Organisational Development and Finance Committee to enable greater triangulation and review.

Accountability Report

Annual Governance Statement

The Resources Committee is responsible for providing the Trust Board with in-year assurance concerning the development and delivery of the Trust's Annual Plan, this covers finance, operation and workforce. The Committee is also responsible for making recommendations to the Trust Board in respect of business development opportunities, in addition to business cases that require capital investment.

Finance Committee

- Met three times during 2018-19 – subsumed into Resources Committee with effect from October 30, 2018

The Committee was responsible for providing detailed scrutiny of the Trust's financial matters, and agreeing and monitoring action plans where remedial plans are required to improve financial performance. The Committee is also responsible for advising the Board on business development opportunities and overseeing capital expenditure against the Trust's approved capital plan.

Workforce and Organisational Development Committee

- Met once during 2018-19 - subsumed into Resources Committee with effect from October 30, 2018

The Committee was responsible for providing clear assurance on all aspects of workforce strategy, planning and organisational development to support the Trust achieving exemplar clinical and professional outcomes and experiences for service users and Trust colleagues. It also had particular responsibility for the development of a supportive and learning organisational culture that promotes the Trust's CORE values of being Caring, Open, Responsible and Effective.

Caring Open Responsible Effective

Accountability Report

Annual Governance Statement

Performance

As Accountable Officer I can confirm that there are processes in place to ensure that the Board has oversight of key areas of performance to ensure that the Trust is meeting its statutory duties and functions.

Quality Equality Impact Assessments (QEIA)

We have a robust Quality Impact Assessment (QIA) process in line with the National Quality Board guidance. The Quality Impact Assessment applies to quality improvement and service development plans as well as efficiency plans eg cost improvement plans.

Our Cost Improvement Programme is monitored by the Cost Improvement Steering Group which reports to the Resources Committee (Sub-Committee of our Trust Board). The Transformation Team supports works with operational managers to support the development of CIP schemes. All CIP schemes are subject to the Trust's Quality Impact Assessment (QIA) process before they are accepted.

We use a Quality Equality Impact Assessment (QEIA) tool to evaluate the impact of any change which may affect either how service users access and use services, or colleagues' working life and developmental opportunities. The first stage of the process is for the operational manager who is responsible for possible change to complete a Determination Matrix to decide whether a QEIA is required. The Determination Matrix assesses the potential impact and likelihood of the change upon service users, workforce, stakeholders and finance, using a combination of risk scores linked to a series of thresholds to indicate whether a QEIA is required.

Where schemes require a QEIA, these are completed and presented to our Clinical Reference Group for challenge and debate prior to approval. If approved, it is authorised by the Trust's Director of Nursing and Medical Director. Once agreed, the operational manager is able to proceed with the change process, and report back to the Quality and Performance Committee for regular review and monitoring against the quality and performance metrics identified within the original QEIA. These are also routinely shared with the Clinical Quality Reference Group (CQRG) for formal review.

The QEIA tool itself assesses each potential change by the three core quality domains ie safety, clinical effectiveness and experience. It considers, for example, the potential impact upon preventable harm, clinical leadership and evidence-based practice, as well as upon people representing each of the Equality Act's nine protected characteristics. The impact on staff is considered as part of the Determination Matrix described above.

The Quality and Performance Committee currently receives triangulated information via the

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monthly Quality and Performance Report. For community hospitals, this includes ward-by-ward analysis of experience data (Friends and Family Test, complaints etc) as well as safety data (Safety Thermometer etc) and HR statistics (rota fill rates, appraisals etc) in order to identify trends or concerns. Similar information is provided for ICTs which gives analysis in respect of safety and HR data. The Committee reports directly to the Trust Board. The Trust Board receives an overall report of measures containing Statistical Process Control charts and exception reports to track quality and productivity outcomes.
The Resources Committee receives routine CIP implementation reports and monitoring information from the CIP Steering Group.

The monitoring information is collated by service area to give oversight of multiple schemes on a particular service. The monitoring information includes the baseline QEIA scoring and progress rating to monitor the quality impact over the duration the change.

Quality Performance

The Trust produces an annual Quality Report in line with Department of Health Guidance. This account looks back at performance in the last year and sets priorities for the following year. The Board approves the Report prior to publication. Arrangements are in place via service delivery groups and trust wide groups to report quality and safety matters to the Quality and Performance Committee, which in turn reports to the Board. This provides assurance on compliance with CQC priorities. Progress against the priorities set out in the Quality Account is also monitored and reviewed.

The Trust has a Learning Assurance Framework to ensure incidents and serious incidents are followed up, thoroughly investigated and learnt from. In 2018-19 there were 11 serious incidents requiring investigation. The Trust has arrangements in place to manage Infection Prevention and Control and the Safeguarding of Children and Vulnerable Adults. These include external partnership arrangements with Local Authorities, Police and Gloucestershire Hospitals NHS Foundation Trust.

The Trust was inspected by the Care Quality Commission in January 2018 and was graded overall as “Good” (an improvement from the 2015 rating of “Requires improvement”), with ninety percent of areas graded as either “Good” or “Outstanding”. An Improvement Action Plan to take forward the areas identified for further improvement and to spread good practice was implemented during 2018-19.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust engages with service users through a range of forums and processes and continues to develop the contribution that volunteers make across our services.

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Financial Performance

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2019, the Trust met these duties, as summarised below, and set out in more detail within the financial statements:

- To break-even on Income and Expenditure — achieved
- To maintain capital expenditure below a set limit — achieved

Within this, the Trust faced significant challenge in delivering the efficiency programme for the year, with plans being developed, monitored and reviewed throughout the year. However, the target was met by year end, with non-recurrent measures replacing in-year shortfalls in recurrent initiatives where required. Whilst this area remains a significant challenge, the Trust's transformational approach to generate and implement efficiency measures has been further revised and strengthened to support delivery.

Checking the correct discharge of statutory functions is managed via the Trust risk management system. No areas of non-compliance have been identified. The Trust met its Agency cap which was set by NHS Improvement as a financial value of Agency Spend for the year.

Data Quality Performance

The Trust has systems in place to verify data quality, including elective waiting time data. These include:

- Validation of data reports and results by service managers and systems users
- Planned internal audits of data by informatics staff.
- Electronic data validation e.g. missed mandatory fields and data out of permitted ranges.
- Performance data monitoring by Trust groups and committees and subsequent enquiries.
- Commissioner scrutiny of activity and quality data.
- User training on systems, e.g. clinical coding.

Fraud and Security Management

The Trust has in place arrangements to manage fraud and security. This includes the use of Security Specialists and a local Counter Fraud team. Annual work plans are formulated which are reported to the Audit and Assurance Committee. Nationally determined standards for security and counter fraud, which are contained within the NHS Standard Contract, are used as benchmarks for performance. These are reported to the Audit and Assurance Committee and Commissioners as required.

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The Trust's major strategic risks and corresponding mitigations, as of 31 March 2019, are summarised in the tables below.

Risk	Mitigation & Key Controls
There is a risk that we do not provide a clear vision for community based services and the case for change to promote increased investment in new models of care is not made robustly; resulting in investment continuing to be focused on acute provision.	● Annual Operating Plan, Quality Priorities, Contractual Agreements and relationships ● Place based model developments, One Place One Budget Sustainability and Transformation Partnership work ● Strategic Intent work with 2gether NHS Foundation Trust
There is a risk that we fail to maximise the use of clinical innovation, business intelligence (including demand) and research and development to maintain and improve the quality of care; resulting in possible harm to patients, poor experience, reduction in quality of care, and loss of reputation for excellence.	● Clinical Governance Framework and processes ● Quality Improvement Priorities and improvement plans ● Staff Development commitments ● Research and Development Strategy development ● Continuous Professional Development plans and investment
There is a risk that we fail to recruit and retain colleagues with right knowledge, skills, experience and values required to deliver sustainable services and support transformation; resulting in care which does not meet the needs of service users.	● Recruitment and Development Strategy and action plan ● Continuous Professional Development plans and investment ● Centralised bank and agency function ● Nursing Associate Programme ● Apprenticeship Programme ● Progression pathway developments ● Staff Engagement processes
There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to our local population; resulting in services which are not optimally designed to meet the needs of service users and carers.	● Friends and Family Test Processes ● Learning Assurance Action Tracker processes ● Your Care Your Opinion Engagement Activities ● Co-production developments
There is a risk that we are too internally focused and do not support system transformation; resulting in services being fragmented and disjointed thereby impacting on quality and service user experience.	● Quality and Performance reporting ● One Gloucestershire commitments ● Processes to develop Strategic Intent

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Risk	Mitigation & Key Controls
There is a risk that lack of mutual understanding of the services and assets provided by ourselves and by other system partners compromises the experience of service users; resulting in service users experiencing care and support which is not seamless.	● Partnership work with One Gloucestershire ● Delivery Pathways ● Cluster working developments
There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to colleagues; resulting in disengagement by colleagues and a culture that does not promote openness.	● Manager Toolkit ● Investors in People ● Freedom to speak up Guardian and other related mechanisms to raise concerns ● Communication and Engagement Strategy ● Core Colleague and Communication processes
There is a risk that we do not support colleagues health and wellbeing in an environment of constant change and demand management; resulting in poor morale and increased levels of sickness and absence.	● Sickness absence monitoring ● Recruitment and Retention Strategy ● Working Well support ● Health and wellbeing initiatives
There is a risk that we under-invest in leadership and management development; resulting in a lack of capacity to nurture a highly engaged and motivated workforce.	● Refresh of Leadership Development Plan ● Manager Toolkit ● Leadership Development
There is a risk that we fail to maintain and develop an infrastructure fit for future services; resulting in fragmented service delivery models and escalating costs.	● Estates Strategy ● Business Plan ● Review of IT Strategy ● Capital Plan
There is a risk that we do not lead on, and invest in, transformation to secure long term sustainability of services; resulting in inability to sustain quality and compromising year on year cost improvement.	● Business Plan ● Cost Improvement Plan and delivery processes ● Quality Equality Impact Assessments ● Workforce planning
There is a risk we do not maintain robust internal controls and governance systems; resulting in potential financial and organisational instability.	● Governance Framework Review and Monitoring ● Use of Resources review ● Monitoring Financial and Quality metrics for assurance

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Risk	Mitigation & Key Controls
There is a risk that system pressures have an unplanned effect on the organisation's ability to ensure ongoing sustainability.	• Full member of Integrated Care System • Monitoring at Board and system level
There is a risk that capacity to progress the Strategic Intent is not sufficient across the two Trusts leading to delays in merger progress impacting on the Strategic Intent with timeliness, impacting on morale, reputation and achievement of benefits.	• Skilled and dedicated programmes management teams in place • Comprehensive governance controls • Two-way engagement with colleagues, service users and stakeholders
There is a risk that competing agendas and demands from primary care, GHFT, GCC, GCCG, ICS in both Gloucestershire and Herefordshire and other partners lead to delays and hamper progress and delivery of benefits.	• Board-level consideration of agendas of all parties to foster collective working • Effective Executive engagement with key partners
There is a risk that having successfully merged (ie completed the transaction) the newly formed organisation fails to maintain momentum and take forward transformational care with pace.	• Comprehensive Post-Transaction Implementation Plan • Key staff to support transformation agenda being identified
There is a risk that changes at a national level relating to health and / or social care impact on the planned transformation.	• NHS Providers membership • Engagement with key providers

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Workforce Planning and Strategies

Our workforce plan for 2019-20 was presented at the Board Development Event in early February 2019. This workforce plan has been prepared in line with the Operational Planning Guidance 2019-20 and our Trust Strategic Objectives.

Approach to Workforce Planning: Our approach to workforce planning has been informed by the recent Trust's refresh of the NHSI Operational Workforce Planning self-assessment tool. As part of the self-assessment process the Trust is strengthening the workforce planning capacity and capability within the organisation including additional training provided by Health Education England in the use of workforce modelling tools, NHSI demand and capacity training for operational colleagues, and, the recent sign up to an ICS-wide workforce planning process for 2019. A joint approach to workforce planning is also being developed in partnership with 2gether NHSFT as part of the merger preparation and business planning.

We have introduced a new governance structure for overseeing workforce and finance by integrating two separate sub-committees of the Board into a single Resources Committee. This supports greater triangulation, joined up planning and assurance regarding the affordability, capacity, capability and transformation of the workforce. The Resources Committee meets bi-monthly and receives a suite of workforce key performance indicators, including turnover, sickness and vacancies. Workforce performance is incorporated into the Quality and Performance dashboard which is presented bi-monthly at the Quality and Performance Committee which oversees the safety and quality of our service delivery to our patients including safer staffing, appraisal, statutory and mandatory training.

Alignment: The Trust workforce planning is aligned internally with the Trust Budget Setting, Activity Plan and Quality Priorities as part of the Trust's internal business planning process to ensure plans are well-modelled, affordable and with sufficient capacity and capability throughout the year to deliver safe, high quality services. The Trust is in the final stages of a project to fully align the Financial Ledger with the Electronic Staff Record to ensure we have the best possible data to inform decision-making. Our workforce planning takes into account the impact of the Cost Improvement Programme, productivity initiatives and improvements in recruitment and retention. It also ensures that the Trust workforce is able to respond appropriately to service changes due to agreed commissioning intentions.

Commissioning intentions for service transformation that will impact in 2019-20 include:

- Extension of complex care at home service into the Forest of Dean
- Extension of HPV school immunisation programme to include boys
- Increased School Nursing services to support increased demand
- Increased musculoskeletal and podiatry as part of the MSK pathway transformation
- Introduction of Specialist Stroke Rehabilitation Unit at Vale Hospital

Any proposed workforce changes are also subject to a full QEIA process with clinical sign off to ensure that quality and equality impacts are fully considered.

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Recruitment of staff within specific staff groups remains a National challenge and a key risk for NHS providers. Taking account of NHSI guidelines for 'Safer Staffing and Developing Workforce Safeguards', we have put plans in place to mitigate our workforce risks and challenges as set out in the following tables:

Description of Workforce Challenge	Impact on workforce	Initiatives in place
Shortage of Nurses	Higher levels of vacancies in Staff Grade Nurses in Community Hospitals and District Nursing in Community teams resulting in higher bank or agency spend.	• Introduction of targeted social media campaign focused on Community Hospital recruitment. A new nurse recruitment film has been produced with staff from GCS and university students to target newly qualified nurses • New Community Nursing Website being developed to link with NHS Jobs for GCS • Training programme in place supporting 11 Nursing Associates - registration with NMC from April 1, 2019. • Development of new Band 7 & 6 Practice Educators and Practice Facilitators to support Trainee Nursing Associates creating new career pathway for experienced nurses to improve retention. • Explore the introduction of a new work experience role supports the strengthening of links with local schools and colleges. • NHSI Retention Programme. The Trust has just joined the third cohort and will have finalized its action plans by the end of Q4 2018-19 • Department of Health Flexible Working Project in partnership with 2gether NHSFT • ICS-wide Recruitment Fayres • Adoption of Proud to Care job site for the ICS – health and social care. • ICS proposal being submitted to the Workforce Steering Group and LWAB to offer bursaries to pump prime and strengthen local supply of our future nursing workforce. Proposed funding to replace the national bursary scheme and offer to include guaranteed interviews for roles within the county.
Shortage of Speech and Language Therapists	Harder to recruit to less attractive community roles. Increase in agency costs to cover vacancies.	• Introduction of integrated team structure to share expertise across services and create clearer career path • Wider ICS wide discussions on options for AHP rotational posts to increase attractiveness of roles
Medical Staffing Shortage	Stability of Medical cover for community hospitals and MIIUs	• Reviewing existing medical model to strengthen resilience • Development of new roles for ENPs and ACPs to reduce the reliance on the medical workforce as this will remain challenged into the future.
Shortage of Physiotherapists	Harder to recruit to less attractive community roles	• Scoping introduction of rotational roles to develop general skills and create sustainable service provision in less attractive community roles • Redesign structure to support Assistant Practitioner roles e.g. Apprenticeships and creating career pathways into registered professions (including Advanced Clinical Practitioner via the Apprenticeship route) • Development of internal programme of support for Return to Practice roles

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Shortage of Occupational Therapists	Harder to recruit to less attractive community roles.	• Wider ICS wide discussions on options for AHP rotational posts to increase development opportunities and attractiveness of roles • Scoping generic AHP roles in community teams to improve skillmix and share expertise Note: This is further compounded by a reduction in funding by commissioners leading to a lack of promotional opportunities for band 5 OTs resulting in turnover.
Loss of clinical expertise in dentistry due to retirement		• Succession planning in place: • Service review and restructuring of existing clinical team • Development plan in place for Dental Officers
Bursaries (Nursing and AHP)		• Development of an ICS bid for HEE support and funding to offer RGN & AHP Degree trainees a bursary and guaranteed job on graduation.
Talent Management, Succession Planning and Leadership Development	To support and maximise employee potential in order to retain a talented and skilled workforce. To equip our leaders with the skills, knowledge and behaviours to lead the Trust and across the ICS.	• ICS wide funding has been secured to deliver a System Wide Leadership Development Programme and accompanying online toolkit to up to 96 leaders throughout 2019. • Deliver a programme of CPD and networking events to the 2018 Alumni of the System Wide Leadership Development Programme. • Develop a coaching approach and framework • To participate in the NHS National High Potential Scheme pilot looking at developing a new structured approach to NHS career development for mid-level leaders who have the potential to reach senior executive roles.

Description of Workforce Risk	Impact of risk (high medium, low)	Risk response strategy	Timescales and progress to date
There is a risk that there will be very little Speech and Language Therapy (SLT) available for the following Community Hospitals commencing in January 2019. North Cotswolds, Dilke Hospital, Vale hospital, Cirencester Hospital and Stroud Hospital.	High	Recruitment to vacant posts agreed and relevant permissions obtained.	Adverts will be placed for a number of B6 SLT's. Staff in post identified to provide some cover to Community Hospitals across the County. This includes locum cover due to commence in the New Year. Regular SLT Recovery Plan meetings planned (2 weekly). x2 maternity leave cover identified as requirement for New Year.
Shortage of partner Trust Radiographers resulting in poor supply of expertise to deliver community imaging	High	Source alternative provision. Train and upskill nurses with radiography / x-ray skills.	Negotiation with alternative provider in progress. Training being scoped.
Recruitment and Retention of qualified nurses & AHPs	High	ICS Workforce Steering Group and the R&R subgroup to focus on initiatives in county. HEE funding for materials and recruitment events. Career pathway development for H&SC opportunities within county. HR People framework in place to assist integrated working and the integration of pathways. Continued reduction in agency spend across the county.	By the end of March 2019 the Cohort 3 nursing retention scheme will finalise an action plan based on the impact assessment for initiatives tried this year. 2019-20 to review a countywide collaborative bank. Continued work on joined up recruitment processes, flow within the countywide system within the HR framework.

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Long-term Vacancies

Description of long-term vacancy, including the time this has been a vacancy post	WTE Impact	Impact on service delivery	Initiatives in place, along with timescales
Band 5 District Nursing – Gloucester and Cheltenham ICTs	-21.5	Increased challenges to team capacity and higher use of bank and agency	On-going advertising campaigns within the Trust and with our ICS partner colleagues, Scoping options for bursary scheme and future RGN & AHP degree training post graduate job offers, roll out of targeted social media outreach – on-going.
Banda 2 & 5 Nurses in community hospitals	-10.34	Increased pressure on Wards – higher agency costs. Also some of the existing staff are newly qualified so put more pressure on again.	As above Skill Mix opportunities and Nurse Associates to be considered.
Band 5 and 6 physio across countywide and ICTs	- 6.0	Permanent advert to recruit and retain	As above. ICS-wide discussions with a view to developing more attractive rotational posts
Band 3 Children's Complex Care support workers	- 4.32	Small team that also provides overnight support – gaps causing service provision issues	Skill Mix opportunities and Nurse Associates to be considered.
Band 6 & 7 Information and Communication Technology specialists	- 3.0	Impact on service provision due to difficulty recruiting with restricted budgets compared to market demand	Consideration of affordability of local RRP and joint appointments.

In order to address these challenges and ensure that the Trust can meet its projected activity growth within available resources, the organisation will continue to focus on maximising opportunities for productivity and efficiency through effecting skill-mix, new ways of working and workforce transformation.

Workforce Transformation

In order to ensure an effective supply and retention of staff, the following initiatives will continue throughout 2019-20 in order to best support and develop our current workforce, underpinned by new routes to career pathways, new innovative roles and new care models linked to known issues:

- Developing Advanced Clinical Practitioners and Extended Nursing Practitioners in MIIUs
- Generic AHP roles in ICTs
- Review staffing model for inpatient wards (linked to opportunities afforded by apprenticeships, nurse associate roles)
- Introduction of Advanced Practitioners linked to review of medical model / GOAM
- Frameworks to support education and career pathways for specialist and advancing practice roles are in development e.g. MSK Physiotherapy

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- Innovative practice development includes the introduction of the Complex Care at Home Service (described earlier), developing the advanced practitioner role for Nursing and AHP's
- Subject to ICS and HEE agreement and funding, the introduction of nursing and AHP bursaries and guaranteed post-graduation jobs
- Continued "Every Contact Counts" health coaching training to colleagues, to widen the pool of staff who can support our enabling active communities programme

New Workforce Initiatives agreed with partners for 2019-20

- Developing new roles: A training programme has been designed to support Apprentices to gain qualifications to take on substantive roles including individual development allowance. As part of this joint initiative across the ICS the Trust is planning to recruit to a second cohort of Trainee Nursing Associate's (TNA's) to commence in September 2019 (first launched in 2017-2018) and confirmation of approval has just been received from Health Education England
- Implementing our Recruitment & Retention Strategy: A refreshed recruitment and retention plan, co-designed with and driven by operational and clinical colleagues, will be in place with a strong emphasis on continual recruitment in key occupations and active membership of the NHSI Retention Cohort 3 Programme 2019. These will underpin our planned reduction in staff turnover
- Flexible Bank Programme: Taking part in the Department of Health Flexible Working Pilot in 2019 with 2gether NHSFT
- Developing our Leadership: Funded by NHS England, HEE and the South West Leadership Academy to deliver further cohorts of the system leadership development programme, Alumni and online toolkit. Pilot ICS for the High Potential Talent Scheme
- Service Transformation: Health Education England funding to support workforce transformation. As part of this funding our Trust was allocated funding to support Advanced Practice roles to support the urgent care agenda across the ICS.
- Developing a framework to introduce apprentice Advanced Clinical Practitioner roles

Developing opportunities: our Learning and Development team has supported colleagues to recruit new apprentices in to the workforce and also upskill and develop substantive employees. Since introduction of the Apprenticeship Levy in April 2017, we have supported 43 apprentices, both clinical and non-clinical, to successfully complete their programme. We currently have 78 apprentices registered on our levy account and we have a further pipeline of new apprentices this year, including up to twelve Leadership and Management at Level 3 & 5, and 2 Assistant Practitioners at Level 5. We do not foresee any funds expiring from the levy account in April 2019.

In order to plan ahead and utilise our levy funds efficiently we are currently reviewing our Training Needs Analysis with all service and department leads to identify the priority areas for apprenticeship training particularly within our Integrated Community Teams and

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Community Hospitals. Results of the analysis will ensure priorities areas are supported by our levy funds for the next twelve months. We have a cohort of Level 5 Assistant Practitioners starting throughout March and we plan to introduce a Level 7 Advanced Clinical Practitioner cohort in September. Our dedicated team supports all apprentices through their learning journey and will continue to introduce new apprenticeship standards to suit the needs of our organisation going forward. We are also committed to working with our ICS partners to maximise the apprenticeship levy across our system.

Strategies to manage agency and locum use: we remain compliant with the NHSI Agency Regulations. Our strategy to drive down agency usage includes continual monitoring of expenditure through an 'Agency Control Group', appropriate clinical sign off for unavoidable (last minute sickness) high cost agency ensuring the appropriate balance between patient quality and safety and cost, advance booking of lower cost agency in areas where a bank supply is not readily available and a greater scrutiny of electronic rostering. This early assessment of resources available will ensure a smoothing out of gaps anticipated in peak historical shortage times such as 'half term'.

The development of a larger and highly engaged clinical bank through a dedicated team who take ownership of this vital workforce has been and will continue to be an important strategy.

Communication with colleagues has and will continue to be key in this space and there is a strong sense of engagement with the clinical and operational teams who focus on resolving issues on a local basis. To support these efforts, financial incentive programmes to work additional shifts by our Band 5 and 6 clinical workforce have been found to be successful. We are also proposing to collaborate with ICS colleagues to create a countywide bank and to support our collective negotiations with agencies.

We have also introduced a number of schemes to improve our staff sickness rate. These include our Fast Track Physiotherapy service for all staff, increased uptake of our staff flu vaccination programme and the introduction of our Working Well service providing counselling and stress management support.

Engagement and Collaborative Working with Commissioners: alignment of workforce planning and local health system is driven by the local Workforce Steering Group which meets monthly and is supported by a Workforce Planning sub-group. This is strategically overseen by the Local Workforce Action Board which meets bi-monthly with representation from all ICS partners to deliver the Joint Strategic Workforce Plan across the ICS. This is being developed with system partners in the first half of 2019 and will be taken through the Trusts' governance structures prior to agreement through the ICS Workforce Steering Group and the One Gloucestershire LWAB.

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We will also work with our Integrated Locality Partnerships as they mature to seek opportunities for new ways of working as we continue to organise our workforce across Primary Care Networks to further support place based primary and community care. It is anticipated that integrated working and rebalancing the workforce will additionally serve to support the new models of care being developed across our ICS.

***Responding to Legislation**:* in anticipation of the NHS Long Term Plan we have put in place a number of key workforce initiatives ahead of the publication of the NHSI Workforce Implementation Plan later in the year. Our workforce plan also incorporates national drivers for demand and capacity modelling and productivity and efficiency including the recommendations made by Lord Carter, developments in education and local alignment with colleagues across the ICS. These have included embedding e-rostering across all services and enabling mobile working for all Integrated Community Teams through use of digital technology and also the introduction of referral centres aligned to Primary Care Networks to ensure efficient and effective use of resources.

Brexit: we have followed the Department of Health operational guidance to support our business continuity planning for a no-deal EU Exit scenario and we are taking the necessary steps to ensure we are operationally ready for the EU Exit as the situation develops. Our expectation is that the impact on our workforce will be negligible.
We will continue to review our workforce plan to implement emerging national policy changes in Workforce and Organisational Development. We welcome the emphasis on workforce issues in the NHS Long Term Plan and are committed to the key workforce element: **'*Backing our workforce'*.**

Declarations of Interest

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all the organisation's obligations under

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equality, diversity and human rights legislation are complied with. This includes compliance with our duties under the Equality Act 2010 by the annual publication of information relating to people who are our employees and those who are affected by our policies and practices, and by the publication of our equality objectives. In addition, this includes compliance with the annual publication of both our NHS Equality Delivery System 2 report and our NHS Workforce Race Equality Standard report.

Review of the economy, efficiency and effectiveness of the use of resources

The Board has established arrangements to ensure it achieves economy, efficiency and effectiveness (or value for money) from the use of resources. The Trust manages its financial resources in accordance with an annual financial plan or budget and has developed a medium term financial plan in order to make informed strategic decisions about resource control and areas of investment and disinvestment.

The Finance Director reports to the Board on actual performance against the financial plan and is accountable for variances in performance. The Board has also established a Finance Committee to review financial performance and scrutinise specific areas, with the objective of ensuring value for money and effectiveness.

The Board's Audit and Risk Assurance Committee is responsible for reviewing the adequacy of the Trust's arrangements for achieving value for money from the use of resources. The committee receives reports from both internal and external auditors in this regard, and highlights areas of concern and proposed actions to the Board. The External Auditor's conclusions on the Board's arrangements for achieving value for money are referred to in their audit report on the Trust's 2018-19 financial statements.

For 2018-19, the Trust ended the year with a Single Oversight Framework segment of 1. We achieved this rating in a year where the cash releasing efficiency savings were set at a particularly challenging level and still invested in our estate, where we have completed considerable work on statutory standards and backlog maintenance and minor schemes to improve the service user environment and our IT infrastructure including mobile working equipment which will support our staff to deliver services and to generate future efficiencies. During 2018-19, we have used a range of methods to identify and deliver efficiency savings, including new business development, redesign of service user pathways and process improvements.

Sustainability

The trust has undertaken risk assessments and has plans in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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Information governance

The Trust has appointed, at Board level, a Caldicott Guardian and a Senior Information Risk Officer to oversee this area of risk. The Trust self-assessed as compliant with NHS Digital's Data Security and Protection Toolkit, and is committed to maintaining full compliance by tracking information flows, auditing compliance with relevant policies and procedures, raising the awareness of staff, training, and improving the Trust's information technology infrastructure.

Information governance refresher training forms part of the Trust's suite of mandatory training, and must be completed by all staff on an annual basis. Training has also been provided to Information Asset Owners throughout the Trust to enable the completion of revised Information Asset Registers which capture the flows of patient-identifiable information through the Trust and provide assurance that where appropriate, information sharing agreements are in place and regularly monitored so as to provide a legal basis for the sharing of such information. The Trust has reported to the Executive, Governance and Audit Committees during the year on its work to prepare the organisation for the implementation of the General Data Protection Regulation and new data security requirements during 2018/19. An internal audit review of the Trust's GDPR processes carried out during the year was rated as low risk.

The Trust is a partner in Gloucestershire's Joining Up Your Information (JUYI) initiative, which seeks to enable shared access to relevant patient information held on clinical systems across partner organisations in order to support the delivery of safe, effective and collaborative care. A similar project began in Herefordshire during the year, with the intent of sharing patient information securely and lawfully across the Herefordshire health economy to provide more effective, safer and more collaborative care. The Trust is an active partner on cross-organisational information governance groups which ensure that information sharing takes place lawfully, and that robust information security procedures and policies are in place to ensure the security of and appropriate access to this sensitive personal information.

The Trust actively encourages the reporting of information governance incidents and near misses. These are investigated internally where it is appropriate to do so, and incident trends and themes are reported to and reviewed by the Information Governance Committee (a sub-committee of the Board's Governance Committee comprising Information Asset Owners from across the Trust) to ensure that learning is appropriately cascaded throughout the organisation. The Trust has had no incidents during the year which met the criteria for reporting to the Information Commissioner, as set out in the Data Security and Protection Incident Reporting Tool.

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Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust is assured that it is well-led having maintained the standards observed by the CQC, including:

- The Trust had an experienced executive and non-executive director and senior leadership team with the skills, abilities, and commitment to lead the delivery of high-quality services
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to ensure staff at all levels understood them in relation to their daily roles
- The Trust involved clinicians, patients and groups from the local community in the development of the strategy and work with the local mental health trust
- Non-executive directors visited all parts of the Trust on a three-monthly basis and fed back to the board to discuss issues staff faced and challenged directors appropriately
- There was evidence of high levels of respect between staff and passionate and knowledgeable managers who motivated their staff and made them feel valued

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Assurance Committee and Quality and Performance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review included feedback from the Head of Internal Audit.

Their opinion is: ***"We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute. The most***

Accountability Report

Annual Governance Statement

that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

"Our opinion is as follows: Generally satisfied with some improvements required

"Governance, risk management and control in relation to business critical areas is generally satisfactory. However, we noted some areas of weakness or non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. The areas where we noted such weaknesses were from 4 medium rated risk reports; Information Governance & Legal – GDPR, Estates & Facilities, Phase 2: BIRTIE access and HR.

"The Phase 2: BIRTIE report had 1 high risk finding relating to the lack of controls over the inclusion of cost centres in BIRTIE Groups. We found seven cost centres that had been included incorrectly within the cost centres list of one BIRTIE Group. This resulted in inappropriate access to non-patient information by the cohort of staff within this group."

Executive Managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by clinical audits, the Trust's External Auditors Opinion, Care Quality Commission (CQC) and NHS Resolution. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board's subcommittees.

A plan to address weaknesses and ensure continuous improvements of the system is in place. The Board's role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

Conclusion

I am happy to report, following review, that no significant internal control issues have been identified.

Paul Roberts .....Chief Executive (Paul Roberts) May 23, 2019 .....Date

Accountability Report

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance

- Value for money is achieved from the resources available to the trust

- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them

- Effective and sound financial management systems are in place

- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Paul Roberts

.....Chief Executive (Paul Roberts) May 23, 2019 .....Date

Accountability Report

Statement of the directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- Make judgements and estimates which are reasonable and prudent;

- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;

- Assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and

- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Paul Roberts .....Chief Executive (Paul Roberts) May 23, 2019 .....Date

Sandra Betney .....Finance Director (Sandra Betney) May 23, 2019 .....Date

Accountability Report

Governance Statement: Annex 1

Attendance at Board meetings and sub-committees 2018-19

Name	Position	Board	Audit & Assurance	Charitable Funds
Number of meetings held		**7**	**6**	**2**
Ingrid Barker	Chair	100% (7 out of 7)		
Paul Roberts	Chief Executive	85% (6 out of 7)		
Susan Mead	Non-Executive Director Snr Independent Director	40% (2 out of 5)		
Graham Russell	Non-Executive Director	100% (7 out of 7)	**6**	
Richard Cryer	Non-Executive Director	71% (5 out of 7)	**6**	**2**
Jan Marriott	Non-Executive Director Snr Independent Director	100% (7 out of 7)	**4**	
Sandra Betney	Deputy Chief Executive Director of Finance	100% (7 out of 7)		**0**
Susan Field	Director of Nursing	85% (6 out of 7)		**2**
Dr Michael Roberts	Medical Director	50% (3 out of 6)		
Candace Plouffe	Chief Operating Officer	85% (6 out of 7)		
Nick Relph	Non-Executive Director	71% (5 out of 7)	**6**	
Nicola Strother Smith	Non-Executive Director	85% (6 out of 7)	**1**	**2**
Dr Amjad Uppal	Medical Director	100% (1 out of 1)		
David Smith	Interim Director of HR (1/7/18) Director of Transition (non-voting) (from 1/7/18)	100% (7 out of 7)		**1**
Neil Savage	Director of Workforce and OD	83% (5 out of 6)		**1**

Directors attended a range of development activities, both as a Board and individually, and attended a number of Private Board meetings.
The Resources Committee replaced the Finance Committee and the Workforce Committee from October 2018.
The Audit and Assurance Committee was revised to the Audit and Risk Assurance Committee from November 2018.

Accountability Report

Governance Statement: Annex 1

Attendance at Board meetings and sub-committees 2018-19

Finance	Resources	Quality & Performance	Workforce & OD	Remuneration & Terms of Service	Date of any change
3	3	6	1	8	
				7	
3		3		2	***
3	3	6		8	
3	3			7	
1	2	5		5	
3	3	1			
1	3	6			
		3			Retired 31/01/19
3	2	5	1		
2	2		1	7	
1	2	6	1	6	Attended A&AR committee to ensure due diligence
					Appointed 01/02/19
1		1	1		No longer attended Board Committees due to change of role
2	3	1			Appointed 01/07/18

*** *Authorised leave of absence due to personal circumstances for a period of the year*

Accountability Report

Governance Statement: Annex 2

Modern Slavery Act 2015: Slavery and Human Trafficking Policy Statement

Introduction

At Gloucestershire Care Services NHS Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by this Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls

Organisation's Structure

Gloucestershire Care Services NHS Trust provides community-based health and care services across Gloucestershire, caring for a population of around 635,000 people. We serve the entirety of Gloucestershire, made up of the large urban communities of Gloucester and Cheltenham, sitting within a largely rural community from the Forest of Dean to the Cotswolds. We have an income of over £100 million.

Our Trust has over 2,700 dedicated staff. Our main role is to support people's health needs in the most appropriate place in the community.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to home as possible.

Our Supply Chains

The Trust supply chain is predominantly service orientated with the majority of its supplier base within the United Kingdom (UK) with our extended supply chain linking into the wider European Economic Area (EAA). NHS Supply Chain is the Trust's largest goods provider and incorporates the principles of the Modern Slavery Act within its code of conduct and ensures these products comply.

Our Policies on Slavery and Human Trafficking

We are fully aware of the responsibilities we have towards our service users, colleagues and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures, such as the Adult Safeguarding Multi-Agency Policy and Procedures.

Accountability Report

Governance Statement: Annex 2

Due Diligence Processes for Slavery and Human Trafficking

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Are working towards the Department of Health (DoH) NHS Procurement & Commercial Standards, which requires a Corporate Social Responsibility (CSR) policy defining the procurement approach to sustainability, modern slavery and all other appropriate ethical standards and approaches.

- Undertake appropriate pre-employment checks on directly employed staff and access temporary staff only through the NHS Improvement approved frameworks ensuring suppliers comply with the same pre-employment checks.

- Uphold best practice and professional codes of conduct relating to procurement and supply.

- Contractual clauses are utilised to ensure that supplier supply chains are monitored and that there is zero tolerance of modern slavery within their supply chain.

- Where any such issues arise within the extended supply chain, the supplier shall act to remove these items from entering the Trust's extended supply chain and implement ethical sourcing programs and supply chain audits to prevent any repetition.

Training

The Trust is planning to offer awareness sessions for staff regarding the recognition of modern day slavery and trafficking.

Our Effectiveness in Combating Slavery and Human Trafficking

Further work is needed to identify how we measure how effective we have been in ensuring that slavery and human trafficking is not taking place in any part of our business or in our supply chain.

The Board of Directors of the Trust will review and update this statement on an annual basis.

This statement is also made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 2018.

Paul Roberts, Chief Executive

Accountability Report

Governance Statement: Annex 3

Chief Executive's Statement – Bribery and tax evasion

Gloucestershire Care Services NHS Trust is committed to the highest standards of ethical conduct and integrity in our respective business activities. Transparent, fair conduct helps to foster deeper relationships of trust between the Trust and its partners. It is vital for our reputation and continued sustainability.

A bribe is a financial advantage or other reward that is offered to, given to, or received by an individual or company (whether directly or indirectly) to induce or influence that individual or company to perform public or corporate functions or duties improperly. Bribery and corruption has a detrimental impact on Trust business by undermining good governance. We benefit from carrying out our functions in a transparent and ethical way and thereby helping to ensure that there is honest, open and fair competition in the NHS. Where there is a level playing field, we can lead by example and deliver excellent services to our patients.

The Trust will not tolerate any form of bribery, whether direct or indirect, by or of its staff, agents or consultants or any persons or entities acting for it or on its behalf. We will not conduct business with service providers, agents or representatives that do not support the Trust's anti-bribery objectives. We reserve the right to terminate contractual arrangements with any third parties acting for or on behalf of the Trust with immediate effect where there is evidence that they have committed acts of bribery, or have engaged in tax evasion.

The board and senior management of the Trust are committed to implementing and enforcing effective systems throughout the organisation to detect and eliminate bribery in accordance with the Bribery Act 2010 and prevent tax evasion in accordance with the Criminal Finances Act 2017. The Trust employs a Local Counter Fraud Specialist who will investigate any allegations of fraud, bribery or corruption.

Policies have been developed outlining our position on preventing bribery and fraud, promoting the highest standards of business conduct, and managing conflicts of interest. These policies apply to all employees(colleagues), as well as agency workers, consultants and contractors acting for or on behalf of the Trust. Employees and others acting for or on behalf of the Trust are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments, and from engaging in any form of tax evasion.

As part of its anti-bribery measures, the Trust is committed to transparent, proportionate, reasonable and bona fide hospitality and promotional expenditure. Such expenditure must only be offered or accepted in accordance with the procedures set out in the Trust's policies. A breach by an employee will be treated as grounds for disciplinary action, which may result in a finding of gross misconduct, and immediate dismissal.

Accountability Report

Governance Statement: Annex 3

Employees and other individuals acting for the Trust should note that bribery is a criminal offence that may result in up to 10 years' imprisonment and/or an unlimited fine for the individual and an unlimited fine for the Trust. If an organisation is successfully prosecuted under the Criminal Finances Act it will face an unlimited fine and possible ancillary sanctions, such as being prohibited from bidding for public contracts.

Every employee and individual acting on behalf of the Trust is responsible for maintaining that Trust's reputation, conducting business honestly and professionally, and playing their part in helping to detect and eradicate bribery. All employees and others acting for, or on behalf of, the Trust are encouraged to report any suspected bribery in accordance with the procedures set out in either the relevant Whistleblowing (Freedom to Speak Up) policy and/or the relevant policy on Fraud, Bribery and Corruption. The Trust will support any individuals who make such a report, provided that it is made in good faith.

Paul Roberts, Chief Executive
May 2019

Accountability Report

Remuneration and Staff Report

Policy for the Remuneration of Directors

The Trust's remuneration policy for Executive Directors observes the Department of Health's Pay Framework for Very Senior Managers (VSMs) in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts (NB although this document dated July 2013 now references organisational forms and bodies no longer in existence, this is the latest available version of the guidance). The Trust's future remuneration policy for Executive Directors will observe these guidelines or any replacement guidelines.

Accordingly, in 2017/18, the pay for the Trust's Chief Executives was in line with that proposed within the Pay Framework for Primary Care Trust (PCT) Chief Executives i.e. it was based on a local population of 0.5million to 1.0million people, weighted for age and deprivation.

Payments made to the Trust VSM Executive Directors were in line with the pay framework.

The following performance-related payments (non-pensionable, non-consolidated, one-off payments) for the year 2017-18 were made during the year 2018-19 following approval by NHSI, based on recommendations from the Remuneration and Terms of Service Committee:

- Sandra Betney (Director of Finance): £3,811
- Candace Plouffe (Chief Operating Officer): £21,060

Accountability Report

Remuneration and Staff Report

Directors' Remuneration (audited) for 2018-19

		Salary	Expense payments (taxable) total to nearest £100	Performance pay & bonuses (bands of £5,000)	Long-term performance pay & bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)**	Total (bands of £5,000)	Notes
Ingrid Barker*	Chair	20-25	300	-	-	-	20-25	
Susan Mead	Non-executive director Sr Independent Director	0-5	100	-	-	-	0-5	
Katie Norton	Chief Executive	55-60	400	-	-	-	55-60	Up to 15/04/18
	Secondment Role							From 16/04/18
Sandra Betney	Deputy Chief Executive Director of Finance	120-125	400	5-10	-	-	130-135	
Richard Cryer	Non-executive director	5-10	1,200	-	-	-	5-10	
Susan Field	Director of Nursing	95-100	1,600	-	-	10-12.5	110-115	
Jan Marriott	Non-executive director	5-10	1,900	-	-	-	5-10	
Dr Michael Roberts	Medical Director	45-50	300	-	-	2.5-5	50-55	Up to 31/01/19
Graham Russell	Non-executive director	5-10	1,100	-	-	-	5-10	
Nicola Strother Smith (Carvell)	Non-executive director	5-10	600	-	-	-	5-10	
Candace Plouffe	Chief Operating Officer	100-105	900	0-5	-	10-12.5	115-120	
Paul Roberts*	Chief Executive	80-85	4,400	-	-	-	85-90	From 16/04/18
David Smith	Interim Director of Human Resources (non-voting)	100-105	400	-	-	-	100-105	
Nick Relph	Non-executive director	5-10	1,700	-	-	-	5-10	
Neil Savage*	Human Resources Director	40-45	-	-	-	45-47.5	85-90	From 01/07/18
Amjad Uppal*	Medical Director	10-15	-	-	-	235-237.5	250-255	From 01/02/19

* Salaries above reflect GCS share of costs

** Pensions column reflects pensions benefits in full

Salary Bands for Joint Posts: (bands of £5,000)

Paul Roberts:	165-170
Ingrid Barker:	45-50
Neil Savage:	80-85
Amjad Uppal:	15-20

Accountability Report

Remuneration and Staff Report

Directors' Remuneration (audited) for 2017-18

		Salary	Expense payments (taxable) total to nearest £1,000	Performance pay & bonuses (bands of £5,000)	Long-term performance pay & bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Notes
Ingrid Barker	Chair	20-25*	3	-	-	-	20-25	
Susan Mead	Non-executive director Sr Independent Director	5-10	2	-	-	-	5-10	
Katie Norton	Chief Executive	140-145	3	-	-	112.5-115	260-265	
Sandra Betney	Deputy Chief Executive Director of Finance	125-130	1	-	-	32.5-35	160-165	
Richard Cryer	Non-executive director	5-10	2	-	-	-	5-10	
Susan Field	Director of Nursing	95-100	2	-	-	0-2.5	95-100	
Jan Marriott	Non-executive director	5-10	2	-	-	-	5-10	
Dr Michael Roberts	Medical Director	45-50	1	-	-	15-17.5	65-70	
Graham Russell	Non-executive director	5-10	1	-	-	-	5-10	
Nicola Strother Smith	Non-executive director	5-10	1	-	-	-	5-10	
Candace Plouffe	Chief Operating Officer	95-100	-	-	-	27.5-30	125-130	
Tina Ricketts	Director of HR (non-voting)	75-80	2	-	-	30-32.5	110-115	Resigned 29/1/18
David Smith	Interim Director of HR (non-voting)	15-20	-	-	-	0-2.5	15-20	Appointed 29/1/18
Nick Relph	Non-executive director	5-10	2	-	-	-	5-10	

Accountability Report

Remuneration and Staff Report

Directors' Pensions Contributions (audited)

Pension contributions for Executive Directors 2018-19.
Non-Executive Directors do not receive pensionable remuneration.

		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash equivalent transfer value at 1 April 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2019	Employer's contribution to pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Sandra Betney	Deputy Chief Executive Director of Finance	(0-2.5)	(0-2.5)	35-40	110-115	691	73	764	18
Candace Plouffe	Chief Operating Officer	0-2.5	2.5-5	15-20	50-55	339	56	395	15
Susan Field	Director of Nursing	0-2.5	2.5-5	25-30	80-85	510	83	593	13
Mike Roberts	Medical Director	0-2.5	0-2.5	10-15	30-35	248	34	282	7
David Smith	Director of Transition	-	-	-	-	-	-	-	-
Katie Norton	Chief Executive	(0-2.5)	(2.5-5)	30-35	100-105	663	47	710	16
Amjad Uppal	Medical Director	10-12.5	25-27.5	35-40	80-85	402	265	667	15
Neil Savage	Human Resources Director	2.5-5	2.5-5	35-40	90-95	592	128	720	16

Accountability Report

Remuneration and Staff Report

Definitions used in the Pensions Contributions Table (previous page)

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown in the table above relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries;

Real Increase CETV
This reflects the increase in CETV effectively funded by the Trust. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pay Multiples (Audited)

The Trust is required to disclose the relationship between the remuneration of its highest-paid Director and the median (average) remuneration of the organisation's workforce.

The midpoint of the banded remuneration of the highest paid Director in the Trust in the financial year 2018-19 was £127,221 (2017-8 143,942). This was 5 times (2017-18 7 times) the median remuneration of the workforce, which was £26,963 (2017-18, £19,409).

In 2018-19, no employees (2017-18, also no employees) received remuneration in excess of the highest-paid Director. Remuneration ranged from £10,132 to £127,221 (2017-18 £10,132 to £143,942).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Accountability Report

Remuneration and Staff Report

Senior Managers' Analysis

The details of staff within the Trust at Agenda for Change Band 8A and above (excluding executive directors) as at March 31, 2019 are shown below. A number of these staff also provide clinical services.

	2018-19		
Banding	**Male**	**Female**	**Total**
8A	10	52	62
8B	4	14	18
8C	6	5	11
8D	1	4	5
	23	**75**	**98**

Staff Numbers 2018-19

The number of staff employed by the Trust in 2018-19, grouped by professional discipline, and excluding staff on outward secondment.

	2018-19		2017-18	
Occupation	**FTE**	**Headcount**	**FTE**	**Headcount**
Administration & Estates	457.14	542	439.3	527
Allied Health Professional	472.28	595	468.1	595
Ancillary staff	82.83	131	91.0	141
Medical & Dental Staff	23.27	36	26.1	40
Nursing, Midwifery, Health Visiting	1078.31	1337	1068.8	1340
Total	**2113.84**	**2641**	**2093.3**	**2643**

Accountability Report

Remuneration and Staff Report

Staff Costs

	Permanent	Other	2018-19 Total	2017-18 Total
	£000	£000	£000	£000
Salaries and wages	65,242	-	65,242	63,232
Social Security Costs	5,454	-	5,454	4,971
Apprenticeship levy	306	-	306	294
Employer's contribution to NHS pensions	8,471	-	8,471	8,249
Pension cost – other	69	-	69	-
Temporary staff	-	1,663	1,663	2,044
Total gross staff costs	**79,542**	**1,663**	**81,205**	**78,790**
Recoveries in respect of seconded staff	(423)		(423)	(261)
Total staff costs	**79,119**	**1,663**	**80,782**	**78,529**

Average number of employees (Whole time equivalent)

	Permanent number	Other number	2018-19 total number	2017-18 total number
Medical and dental	33	1	34	26
Administration and estates	566	7	573	447
Healthcare assistants and other support staff	346	32	378	120
Nursing, midwifery and health visiting staff	759	37	796	1,109
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	411	2	413	473
Other	-	-	-	-
Total average numbers	**2,115**	**79**	**2,194**	**2,175**

Accountability Report

Remuneration and Staff Report

Staff Composition (Audited)

The gender composition of the Trust is detailed on the following table:

	Male		Female		
Role	**Number**	**Percent**	**Number**	**Percent**	**Total**
Board members	7	50%	7	50%	14
Senior Managers	22	22.7%	75	77.3%	97
All other staff	233	9.2%	2,307	90.8%	2,540
Grand Total	256	9.7%	2,385	90.3%	2,641

The main change in gender composition of the Trust was a small decrease in female representation on the board from 58% to 50%.

Trust Sickness Absence: 12 months to Feb 2019 (Audited)

Staff Group	12 month sickness rate
Additional Prof Scientific and Technical	**7.3%**
Additional Clinical Services	**6.4%**
Administrative and Clerical	**4.5%**
Allied Health Professionals	**2.8%**
Estates and Ancillary	**5.1%**
Medical and Dental	**3.1%**
Nursing and Midwifery Registered	**5.4%**
Students	**0.1%**
Total	**4.9%**

Figures converted by DoH to Best Estimates of required data items			Statistics published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	**Adjusted FTE days lost to Cabinet Office definitions**	**Average sick days per FTE**	**FTE days available**	**FTE days lost to sickness absence**
2086.95	**22,993.94**	**11.02**	**761,735**	**37,301**

Accountability Report

Remuneration and Staff Report

Staff Policies on Disabled Employees

The Trust is fully committed to ensuring equal opportunities, and this is reflected by its accreditation by Investors in People, confirmed for a further three year period in March 2017. It is also evidenced by the Trust's continued application of its Equality and Human Rights Policy, as well as its Recruitment and Selection Policy and Procedure, which together demonstrate that the Trust gives full and fair consideration for applications for employment by disabled persons, namely:

- All recruitment uses the NHS Jobs system in order to ensure that personal details are removed for the shortlisting stage
- Advertising seeks to attract suitably qualified, skilled and experienced candidates from all sections of the community and the existing workforce
- The Trust operates a Guaranteed Interview Scheme, so that people with disabilities are guaranteed an interview as long as they meet the minimum criteria: in recognition of this work, the Trust holds Two Ticks and Mindful Employer status
- Training has been developed to ensure that those responsible for making selection decisions do not discriminate, consciously or unconsciously, when making such decisions;
- Where there is an identified need, the Trust takes positive action to try and encourage a diverse range of applicants

Equally, all people are treated fairly when in employment with the Trust:

- The Trust actively avoids practices that would put a disabled person at a disadvantage, compared to those who are not disabled
- The Trust makes reasonable adjustments at work, such as removing or altering a physical feature, or providing a reasonable means of avoiding such a feature, where it would put a disabled person at a substantial disadvantage, compared to those who are not disabled
- The Trust provides auxiliary aids where a disabled person would otherwise be put at a substantial disadvantage, compared to those who are not disabled
- All employees, irrespective of disability status, have access to regular supervision, an annual review of their performance, and a personal development plan which identifies their training needs: moreover, the reasons for choosing certain employees for training is clear and based on sound judgements

In terms of career progression, everyone who applies for a promotion within the Trust receives fair treatment and is considered solely on their ability to do the job. Furthermore, no applicant is placed at a disadvantage by requirements or conditions that are not essential for the performance of the job.

Accountability Report

Remuneration and Staff Report

Equality Delivery System

The Trust recognises and the importance of embedding equality, diversity and inclusion principles and practices throughout the organisation. The Trust wants our service users, and workforce to be confident about our progress and commitment to eliminating discrimination, bullying, harassment, victimisation and promoting equality.

The Trust values its workforce and wants to create working environments so they can deliver equitable services. Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety (NHS England 2019). The principles of equality, diversity and inclusion are threaded throughout the vision and values of the Trust.

The Trust is fully committed to ensuring equal opportunities, and this is reflected by its accreditation by Investors in People and Disability Confident Employer Level One. It is also evidenced by the Trust's continued application of its Equality and Human Rights Policy, as well as its Recruitment and Selection Policy and Procedure, which together demonstrate that the Trust gives full and fair consideration for applications for employment by disabled persons namely;

- All recruitment uses the NHS Jobs system in order to ensure that personal details are removed for the shortlisting stage
- Advertising seeks to attract suitably qualified, skilled and experienced candidates from all sections of the community and the existing workforce
- The Trust operates a Guaranteed Interview Scheme, so that people with disabilities are guaranteed an interview as long as they meet the minimum criteria: in recognition of this work, the Trust holds Two Ticks and Mindful Employer status

Equally, all people are treated fairly when in employment with the Trust i.e.

- The Trust actively avoids practices that would put a disabled person at a disadvantage, compared to those who are not disabled
- The Trust makes reasonable adjustments at work, such as removing or altering a physical feature, or providing a reasonable means of avoiding such a feature, where it would put a disabled person at a substantial disadvantage, compared to those who are not disabled
- The Trust provides auxiliary aids where a disabled person would otherwise be put at a substantial disadvantage, compared to those who are not disabled
- All employees, irrespective of disability status, have access to regular supervision, an annual review of their performance, and a personal development plan which identifies their training needs: moreover, the reasons for choosing certain employees for training is clear and based on sound judgements

Accountability Report

Remuneration and Staff Report

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (metrics) to improve the experiences of disabled colleagues in the NHS.

Through the Public Sector Equality Duty, the Trust must capture equality related information and report on it.

The Accessible Information Standard (AIS) Standard aims to ensure that disabled patients (including carers and parents, where applicable) receive accessible information and have appropriate support to help them communicate.

The purpose of the Equality Delivery System, now refreshed to EDS2, is to help NHS organisations review and improve their performance for people with protected characteristics.

A representative and supported workforce	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	Training and development opportunities are taken up and positively evaluated by all staff
	When at work, staff are free from abuse, harassment, bullying and violence from any source
	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	Staff report positive experiences of their membership of the workforce
Inclusive leadership	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisation
	Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed
	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

However, with the exception to the Workforce Race Equality Standard (WRES), the majority of Trust workforce information in 2018-19 was analysed again at a more generalized level. It is still a challenge to encourage colleagues to disclose details of, for example, their disabilities, sexual orientation or religion, meaning that baseline data was not indicative of the workforce as a whole. The Trust continues to work to improve data reporting.

Accountability Report

Remuneration and Staff Report

Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) aims to ensure colleagues from Black, Asian and Minority Ethnic BAME) backgrounds are treated fairly at work and have equal access to career opportunities and equality of experience. Progress is demonstrated against a number of workforce race equality indicators. The Trust's submission for 2018 is set out in the following table.

Indicator	White colleagues	Black and Minority Ethic (BME) colleagues
1. Percentage of Black and Minority (BME) staff compared with the overall workforce		5% of the workforce is from a BAME background. There has been an increase in the proportion of BAME staff compared to 2015-16 (4.1%) and 2014-15 (3.6%). We are in line with BAME representation in Gloucester-shire, which is 4.6%
2. Relative likelihood of staff being appointed from shortlisting	2.34 times more likely to be appointed from shortlisting	This is a continually worsening position, compared with 2016-17 (2.29), 2015-16 (2.20) and 2014-15 (1.29).
3. Relative likelihood of staff entering the formal disciplinary process		Although proportionally, BAME colleagues are 1.17 times more likely to enter the formal disciplinary pro-cess than white colleagues, this is a significant reduction compared to 1.67 in 2016-17, 2.21 in 2015-16 and 1.8 in 2014-15
4. Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD)	1.09 times as likely to access non-mandatory training and CPD	This is a slightly worse figure than 2016-17 (1.04) and similar to 2014-15 (1.08)
5. Percentage of staff experiencing harassment, bullying or abuse from service users, relatives or the public in the last 12 months	31%	33% The experiences of BAME colleagues have worsened since 2016-17 (26%) to align more closely with the ex-perience of white colleagues in this regard
6. Percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months	21%	17% Whilst the experiences of BAME colleagues are better than those of white colleagues, there has been a negative increase from 13% in 2016-17. Until this year, BME colleagues had seen a decrease in actual terms (from 25% in 2015-16, and 31% in 2014-15).
7. Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	90%	77% 2016-17 was the first time that there was a sufficient response from BAME colleagues to include data from this colleagues sub-group, when the result was 87% - so this result shows a worsening picture.

Accountability Report

Remuneration and Staff Report

Workforce Race Equality Standard (contd)

8. Percentage of staff who have experienced discrimination from a manager or team leader, or other colleague, in the last 12 months	7%	8% The experience of BAME colleagues was 17% in both previous reporting years, so this is a significant improvement. However, the experiences of white colleagues has worsened from 4% in both previous reporting periods
9. Percentage difference between the Trust's Board voting membership and its overall workforce		There remains a difference between the Board – where there is no BAME representation – and the overall workforce

Expenditure on consultancy

In 2018-19 the Trust spent £148,000 on external consultancy from companies supporting specific projects around estates, HR and finance. This was because specific internal expertise did no exist to complete these projects.

Off-Payroll Engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2019	**12**
Of which, the number that have existed for:	
Less than one year at the time of reporting	**0**
Between one and two years at the time of reporting	**2**
Between two and three years at the time of reporting	**10**
Between three and four years at the time of reporting	**0**
Four or more years at the time of reporting	**0**

Accountability Report

Remuneration and Staff Report

New Off-Payroll Engagements

For all new off-payroll engagements, or those that reached six months in duration between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration between 1 April 2018 and 31 March 2019	**2**
Of which:	
Number assessed as caught by IR35	**2**
Number assessed as not caught by IR35	
Number engaged directly (via PSC contracted to entity) and are on the entity's payroll	
Number of engagements reassessed for consistency / assurance purposes during the year	**0**
Number of engagements that saw a change to IR35 status following consistency review	**0**

Off-payroll board member or senior official engagements

For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility during the year	**0**
Total number of individuals on-payroll and off-payroll that have been deemed 'Board Members and / or senior officials with significant financial responsibility' during the financial year. This figure must include both on payroll and off payroll engagements.	**0**

Accountability Report

Remuneration and Staff Report

Exit packages

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment elements included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
Less than £10,000								
£10,000 to £25,000								
£25,001 to £50,000								
£50,001 to £100,000	1	86						
£100,001 to £150,000								
£150,001 to £200,000								
More than £200,000								
Totals	**1**	**86**						

Redundancy and other departure costs were paid in accordance with the provisions of the Medical and Dental or Agenda for Change Schemes as appropriate. Exit costs are accounted for in full in the year of departure. In 2018-19, the Trust did not agree any early retirements, so there are no additional costs to be met. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

No non-contractual payments in lieu of notice were paid. No non-contractual severance payments were made following judicial mediation, and therefore none related to non-contractual payments in-lieu-of-notice. No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

I hereby confirm that the above Accountability Report is a true and accurate representation of Trust activities in 2018-19.

Paul Roberts .....Chief Executive (Paul Roberts) May 23, 2019 .....Date

Gloucestershire Care Services NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

		Group	
		2018/19	2017/18
	Note	£000	£000
Operating income from patient care activities	3	112,668	109,889
Other operating income	4	5,983	4,710
Operating expenses	6, 8	(112,530)	(123,164)
Operating surplus/(deficit) from continuing operations		**6,121**	**(8,565)**
Finance income	10	107	34
PDC dividends payable		(1,739)	(1,666)
Net finance costs		**(1,632)**	**(1,632)**
Other gains / (losses)	11	(56)	-
Surplus / (deficit) for the year from continuing operations		**4,433**	**(10,197)**
Surplus / (deficit) for the year		**4,433**	**(10,197)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(5,709)
Revaluations	17	4,069	-
Total comprehensive income / (expense) for the period		**8,502**	**(15,906)**
Surplus/ (deficit) for the period attributable to:			
Gloucestershire Care Services NHS Trust		4,433	(10,197)
TOTAL		**4,433**	**(10,197)**
Total comprehensive income/ (expense) for the period attributable to:			
Gloucestershire Care Services NHS Trust		8,502	(15,906)
TOTAL		**8,502**	**(15,906)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		4,433	(10,197)
Remove impact of consolidating NHS charitable fund		-	(22)
Remove net impairments not scoring to the Departmental expenditure limit		885	15,685
Remove I&E impact of capital grants and donations		(249)	97
Adjusted financial performance surplus		**5,069**	**5,563**

The adjusted position excluding Provider Sustainability Funding is £1,107k

Statement of Financial Position

		Group		Trust	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	829	1,000	829	1,000
Property, plant and equipment	14,15	63,465	58,859	63,315	58,709
Total non-current assets		**64,294**	**59,859**	**64,144**	**59,709**
Current assets					
Inventories	19	288	228	288	228
Receivables	20	8,793	6,762	8,778	6,756
Cash and cash equivalents	21	17,883	12,412	17,837	12,354
Total current assets		**26,964**	**19,402**	**26,903**	**19,338**
Current liabilities					
Trade and other payables	22	(10,987)	(9,563)	(10,972)	(9,545)
Borrowings	24	(76)	(148)	(76)	(148)
Provisions	26	(371)	(160)	(371)	(160)
Other liabilities	23	(389)	(123)	(389)	(123)
Total current liabilities		**(11,823)**	**(9,994)**	**(11,808)**	**(9,976)**
Total assets less current liabilities		**79,435**	**69,267**	**79,239**	**69,071**
Non-current liabilities					
Borrowings	24	(1,593)	(221)	(1,593)	(221)
Total non-current liabilities		**(1,593)**	**(221)**	**(1,593)**	**(221)**
Total assets employed		**77,842**	**69,046**	**77,646**	**68,850**
Financed by					
Public dividend capital		80,276	79,982	80,276	79,982
Revaluation reserve		4,679	610	4,679	610
Other reserves		(2,398)	(2,398)	(2,398)	(2,398)
Income and expenditure reserve		(4,911)	(9,344)	(4,911)	(9,344)
Charitable fund reserves	18	196	196	-	-
Total taxpayers' equity		**77,842**	**69,046**	**77,646**	**68,850**

The notes on pages 8 to 41 form part of these accounts.

Name Paul Roberts
Position Chief Executive
Date 23rd May 2019

Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**79,982**	**610**	**(2,398)**	**(9,344)**	**196**	**69,046**
Surplus for the year	-	-	-	4,433	-	**4,433**
Revaluations	-	4,069	-	-	-	**4,069**
Public dividend capital received	294	-	-	-	-	**294**
Taxpayers' and others' equity at 31 March 2019	**80,276**	**4,679**	**(2,398)**	**(4,911)**	**196**	**77,842**

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**79,982**	**6,319**	**(2,398)**	**875**	**174**	**84,952**
Surplus/(deficit) for the year	-	-	-	(10,219)	22	**(10,197)**
Impairments	-	(5,709)	-	-	-	**(5,709)**
Taxpayers' and others' equity at 31 March 2018	**79,982**	**610**	**(2,398)**	**(9,344)**	**196**	**69,046**

Statement of Changes in Equity for the year ended 31 March 2019

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**79,982**	**610**	**(2,398)**	**(9,344)**	**68,850**
Surplus for the year	-	-	-	4,433	**4,433**
Revaluations	-	4,069	-	-	**4,069**
Public dividend capital received	294	-	-	-	**294**
Taxpayers' and others' equity at 31 March 2019	**80,276**	**4,679**	**(2,398)**	**(4,911)**	**77,646**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**79,982**	**6,319**	**(2,398)**	**875**	**84,778**
Deficit for the year	-	-	-	(10,219)	**(10,219)**
Impairments	-	(5,709)	-	-	**(5,709)**
Taxpayers' and others' equity at 31 March 2018	**79,982**	**610**	**(2,398)**	**(9,344)**	**68,850**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves are shown in respect of donated assets included on the Trust's balance sheet.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 18.

Statement of Cash Flows

	Note	Group 2018/19 £000	Group 2017/18 £000	Trust 2018/19 £000	Trust 2017/18 £000
Cash flows from operating activities					
Operating surplus / (deficit)		6,121	(8,565)	6,121	(8,587)
Non-cash income and expense:				-	-
Depreciation and amortisation	6.1	4,414	4,184	4,414	4,184
Net impairments	7	885	15,685	885	15,685
Income recognised in respect of capital donations	4	(340)	-	(340)	-
(Increase) / decrease in receivables and other assets		(2,042)	192	(2,042)	192
(Increase) / decrease in inventories		(60)	(1)	(60)	(1)
Increase / (decrease) in payables and other liabilities		1,697	(1,519)	1,697	(1,519)
Increase / (decrease) in provisions		211	(905)	211	(905)
Movements in charitable fund working capital		(12)	(65)	-	-
Net cash flows from / (used in) operating activities		**10,874**	**9,006**	**10,886**	**9,049**
Financial assets are classified and subsequently measured at amortised cost.					
Interest received		107	34	107	34
Purchase of PPE and investment property		(4,013)	(3,192)	(4,013)	(3,192)
Net cash flows from / (used in) investing activities		**(3,906)**	**(3,158)**	**(3,906)**	**(3,158)**
Cash flows from financing activities					
Public dividend capital received		294	-	294	-
Capital element of finance lease rental payments		(147)	(74)	(147)	(74)
PDC dividend (paid) / refunded		(1,644)	(1,743)	(1,644)	(1,743)
Net cash flows from / (used in) financing activities		**(1,497)**	**(1,817)**	**(1,497)**	**(1,817)**
Increase / (decrease) in cash and cash equivalents		**5,471**	**4,031**	**5,483**	**4,074**
Cash and cash equivalents at 1 April - brought forward		**12,412**	**8,381**	**12,354**	**8,280**
Cash and cash equivalents at 31 March 2019	21	**17,883**	**12,412**	**17,837**	**12,354**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of Preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

In preparation of the year end accounts the Directors are required to undertake an assessment as to whether the Trust will continue as a going concern.

As noted within the annual report, Gloucestershire Care Services NHS Trust is due to be acquired by 2Gether NHS Foundation Trust on 30 September 2019. Whilst Gloucestershire Care Services NHS Trust will cease to operate on the conclusion of the transaction, the services currently provided by Gloucestershire Care Services NHS Trust will continue within the new entity, who will receive the relevant funding going forward. Therefore in accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services is the key consideration when assessing if the accounts should be prepared on a going concern basis.

Through considering the factors noted above and relevant accounting standards, the Directors have confirmed that the service will continue to be delivered for the foreseeable future and therefore the accounts have been prepared under a going concern basis as set out in IAS 1.

Note 1.3 Consolidation

NHS Charitable Funds
The Trust is the corporate Trustee to Gloucestershire Care Services NHS charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The Trust elected at 31/3/16 not to show the value of any attributable surplus pension scheme assets on its balance sheet as there is no scenario where these would become the property of the Trust. The assets are measured at fair value, and the liabilities at the present value of future obligations.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	82
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified and subsequently measured at amortised cost.
Financial liabilities are classified and subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust has not adopted IFRS 16 in these accounts and considers that the impact when adopted will be immaterial.

Note 1.12.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.15 Sources of estimation uncertainty

The following are assumptions about the future and other major estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Asset lives - the Trust has made assumptions about the length of time for which its buildings will be in use. Where there are new buildings, the Trust assumes a 60-year initial life.

Indices used for asset valuations are published independently by the Building Cost Information Service (BCIS) of the Royal Institution of Chartered Surveyors (RICS). BCIS is the leading provider of cost and price information and its indices are widely used in the valuation of specialised operational assets across both the public and private sector. The aim is to provide a reliable indication of cost in a given location at a given date in time.

Note 1.16 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 2 Operating Segments

The Trust has determined that it has only one reportable segment. All services delivered by the Trust are as an NHS Community Services Provider and over 80% of income is earned through an over-riding block contract with NHS Gloucestershire Clinical Commissioning Group.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Community services		
Information Service (BCIS) of the Royal Institution of Chartered Surveyors (RICS). BCIS is	101,409	100,478
Income from other sources (e.g. local authorities)	9,876	9,411
All services		
Agenda for Change pay award central funding	1,383	-
Total income from activities	**112,668**	**109,889**

Note 3.2 Income from patient care activities (by source)

	2018/19	2017/18
Income from patient care activities received from:	**£000**	**£000**
NHS England	6,634	6,644
Clinical commissioning groups	94,775	93,834
Department of Health and Social Care	1,449	126
Other NHS providers	6,108	6,207
NHS other	561	-
Local authorities	1,898	2,071
Injury cost recovery scheme	170	257
Non NHS: other	1,073	750
Total income from activities	**112,668**	**109,889**
Of which:		
Related to continuing operations	112,668	109,889

Note 4 Other operating income (Group)

	2018/19	2017/18
	£000	**£000**
Other operating income from contracts with customers:		
Research and development (contract)	26	22
Education and training (excluding notional apprenticeship levy income)	469	378
Non-patient care services to other bodies	196	56
Provider sustainability / sustainability and transformation fund income (PSF / STF)	3,962	3,642
Other contract income	755	504
Other non-contract operating income:		
Education and training - notional income from apprenticeship fund	193	54
Receipt of capital grants and donations	340	-
Charitable and other contributions to expenditure	1	-
Rental revenue from finance leases	12	-
Charitable fund incoming resources	29	54
Total other operating income	**5,983**	**4,710**
Of which:		
Related to continuing operations	5,983	4,710

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	123

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

The majority of the Trust's contracts satisfy performance obligations by delivering indicative level of services rather than satisfaction being conditional upon achievement of a specific activity/action. There are some cases where performance obligations are deemed variable, for these income is only recognised once the financial assets are classified and subsequently measured at amortised cost.

All obligations have been satisfied during the year.

Note 6 Operating expenses

Note 6.1 Operating expenses (Group)

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,515	4,396
Purchase of healthcare from non-NHS and non-DHSC bodies	1,643	1,435
Purchase of social care	-	88
Staff and executive directors costs	80,696	78,529
Remuneration of non-executive directors	68	59
Supplies and services - clinical (excluding drugs costs)	4,219	3,767
Supplies and services - general	2,996	3,136
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,768	3,186
Consultancy costs	148	159
Establishment	270	228
Premises	6,446	4,110
Transport (including patient travel)	1,706	1,609
Depreciation on property, plant and equipment	4,074	3,603
Amortisation on intangible assets	340	581
Net impairments	885	15,685
Movement in credit loss allowance: contract receivables / contract assets	(101)	-
Financial assets are classified and subsequently measured at amortised cost.	-	(155)
Audit fees payable to the external auditor		
audit services- statutory audit	48	39
other auditor remuneration (external auditor only)	-	3
Internal audit costs	40	40
Clinical negligence	200	286
Legal fees	182	206
Insurance	125	122
Research and development	-	-
Education and training	768	578
Rentals under operating leases	1,351	1,433
Redundancy	86	-
Hospitality	-	4
Losses, ex gratia & special payments	27	3
Other NHS charitable fund resources expended	26	29
Other	4	5
Total	**112,530**	**123,164**
Of which:		
Related to continuing operations	112,530	123,164

Note 6.2 Other auditor remuneration (Group)

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	3
Total	-	3

Note 6.3 Limitation on auditor's liability (Group)

The limitation on the auditor's liability is £2m (2017/18 £2m).

Note 7 Impairment of assets (Group)

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / (deficit) resulting from:		
Changes in market price	885	15,685
Total net impairments charged to operating surplus / (deficit)	**885**	**15,685**
Impairments charged to the revaluation reserve	-	5,709
Total net impairments	**885**	**21,394**

The impairments charged in the year relate to the updated revaluation on the Trust's land and specialised buildings. The accounting entries made in respect of the revaluation are explained at note 17.

Note 8 Employee benefits (Group)

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	65,242	63,232
Social security costs	5,454	4,971
Apprenticeship levy	306	294
Employer's contributions to NHS pensions	8,471	8,249
Pension cost - other (LGPS and NEST)	69	-
Temporary staff (including agency)	1,663	2,044
Total gross staff costs	**81,205**	**78,790**
Recoveries in respect of seconded staff	(423)	(261)
Total staff costs	**80,782**	**78,529**

Note 8.1 Retirements due to ill-health (Group)

During 2018/19 there was 1 early retirement from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is 0k (0k in 2017/18).

Note 9 Operating leases (Group)

Note 9.1 Gloucestershire Care Services NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Gloucestershire Care Services NHS Trust is the lessee.

In addition to several immaterial leases there are 2 material building leases, the headquarters building at Edward Jenner Court and a clinical building Southgate Moorings, Gloucester.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	749	734
Contingent rents	602	699
Total	**1,351**	**1,433**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	952	833
- later than one year and not later than five years;	3,095	3,065
- later than five years.	856	4,735
Total	**4,903**	**8,633**

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	107	34
Total finance income	**107**	**34**

Note 11 Other gains / (losses) (Group)

	2018/19 £000	2017/18 £000
Losses on disposal of assets	(56)	-
Total losses on disposal of assets	**(56)**	**-**

Note 12 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's surplus/(deficit) for the period was £5 million (2017/18: £(10)million). The Trust's total comprehensive income/(expense) for the period was £9 million (2017/18: £(16) million).

Note 13.1 Intangible assets - 2018/19

Group	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	-	1,945	1,945
Additions	169	-	169
Valuation / gross cost at 31 March 2019	169	1,945	2,114
Amortisation at 1 April 2018 - brought forward	-	945	945
Provided during the year	23	317	340
Amortisation at 31 March 2019	23	1,262	1,285
Net book value at 31 March 2019	146	683	829
Net book value at 1 April 2018	-	1,000	1,000

Note 13.2 Intangible assets - 2017/18

Group	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	-	1,945	1,945
Valuation / gross cost at 31 March 2018	-	1,945	1,945
Amortisation at 1 April 2017 - brought forward	-	364	364
Provided during the year	-	581	581
Amortisation at 31 March 2018	-	945	945
Net book value at 31 March 2018	-	1,000	1,000
Net book value at 1 April 2017	-	1,581	1,581

Note 13.3 Intangible assets - 2018/19

Trust	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	-	1,945	1,945
Additions	169	-	169
Valuation / gross cost at 31 March 2019	169	1,945	2,114
Amortisation at 1 April 2018 - brought forward	-	945	945
Provided during the year	23	317	340
Amortisation at 31 March 2019	23	1,262	1,285
Net book value at 31 March 2019	146	683	829
Net book value at 1 April 2018	-	1,000	1,000

Note 13.4 Intangible assets - 2017/18

Trust	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	-	1,945	1,945
Valuation / gross cost at 31 March 2018	-	1,945	1,945
Amortisation at 1 April 2017 - brought forward	-	364	364
Provided during the year	-	581	581
Amortisation at 31 March 2018	-	945	945
Net book value at 31 March 2018	-	1,000	1,000
Net book value at 1 April 2017	-	1,581	1,581

Note 14.1 Property, plant and equipment - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**150**	**66,839**
Additions	-	253	-	5,212	87	-	-	-	-	**5,552**
Impairments	-	(885)	-	-	-	-	-	-	-	**(885)**
Revaluations	575	3,494	-	-	-	-	-	-	-	**4,069**
Reclassifications	-	3,698	(241)	(6,726)	807	-	2,631	(169)	-	-
Disposals / derecognition	-	(37)	-	-	(30)	(2)	-	-	-	**(69)**
Valuation/gross cost at 31 March 2019	**7,140**	**50,024**	**-**	**1,612**	**6,633**	**158**	**8,273**	**1,516**	**150**	**75,506**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**-**	**7,980**
Provided during the year	-	1,089	(241)	-	716	33	2,373	104	-	**4,074**
Disposals / derecognition	-	(3)	-	-	(9)	(1)	-	-	-	**(13)**
Accumulated depreciation at 31 March 2019	**-**	**1,879**	**-**	**-**	**3,674**	**151**	**5,475**	**862**	**-**	**12,041**
Net book value at 31 March 2019	**7,140**	**48,145**	**-**	**1,612**	**2,959**	**7**	**2,798**	**654**	**150**	**63,465**
Net book value at 1 April 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**150**	**58,859**

Note 14.2 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**150**	**96,051**
Additions	-	424	-	1,726	279	-	790	116	-	**3,335**
Impairments	(5,034)	(16,360)	-	-	-	-	-	-	-	**(21,394)**
Revaluations	-	(11,153)	-	-	-	-	-	-	-	**(11,153)**
Reclassifications	(200)	66	241	(41)	(117)	-	(44)	95	-	-
Valuation/gross cost at 31 March 2018	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**150**	**66,839**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**-**	**15,530**
Provided during the year	-	793	241	-	545	27	1,791	206	-	**3,603**
Revaluations	-	(11,153)	-	-	-	-	-	-	-	**(11,153)**
Accumulated depreciation at 31 March 2018	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**-**	**7,980**
Net book value at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**150**	**58,859**
Net book value at 1 April 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**150**	**80,521**

Note 14.3 Property, plant and equipment financing - 2018/19

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	7,140	45,511	1,612	2,861	7	2,512	654	150	**60,447**
Finance leased	-	1,448	-	-	-	286	-	-	**1,734**
Owned - donated	-	1,186	-	98	-	-	-	-	**1,284**
NBV total at 31 March 2019	**7,140**	**48,145**	**1,612**	**2,959**	**7**	**2,798**	**654**	**150**	**63,465**

Note 14.4 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	6,565	41,686	3,126	2,635	41	2,193	927	150	**57,323**
Finance leased	-	-	-	-	-	347	-	-	**347**
Owned - donated	-	1,022	-	167	-	-	-	-	**1,189**
NBV total at 31 March 2018	**6,565**	**42,708**	**3,126**	**2,802**	**41**	**2,540**	**927**	**150**	**58,859**

Note 15.1 Property, plant and equipment - 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**66,689**
Additions	-	253	-	5,212	87	-	-	-	**5,552**
Impairments	-	(885)	-	-	-	-	-	-	**(885)**
Revaluations	575	3,494	-	-	-	-	-	-	**4,069**
Reclassifications	-	3,698	(241)	(6,726)	807	-	2,631	(169)	-
Disposals / derecognition	-	(37)	-	-	(30)	(2)	-	-	**(69)**
Valuation/gross cost at 31 March 2019	**7,140**	**50,024**	**-**	**1,612**	**6,633**	**158**	**8,273**	**1,516**	**75,356**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**7,980**
Provided during the year	-	1,089	(241)	-	716	33	2,373	104	**4,074**
Disposals / derecognition	-	(3)	-	-	(9)	(1)	-	-	**(13)**
Accumulated depreciation at 31 March 2019	**-**	**1,879**	**-**	**-**	**3,674**	**151**	**5,475**	**862**	**12,041**
Net book value at 31 March 2019	**7,140**	**48,145**	**-**	**1,612**	**2,959**	**7**	**2,798**	**654**	**63,315**
Net book value at 1 April 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**58,709**

Note 15.2 Property, plant and equipment - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**95,901**
Additions	-	424	-	1,726	279	-	790	116	**3,335**
Impairments	(5,034)	(16,360)	-	-	-	-	-	-	**(21,394)**
Revaluations	-	(11,153)	-	-	-	-	-	-	**(11,153)**
Reclassifications	(200)	66	241	(41)	(117)	-	(44)	95	-
Valuation/gross cost at 31 March 2018	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**66,689**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**15,530**
Provided during the year	-	793	241	-	545	27	1,791	206	**3,603**
Revaluations	-	(11,153)	-	-	-	-	-	-	**(11,153)**
Accumulated depreciation at 31 March 2018	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**7,980**
Net book value at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**58,709**
Net book value at 1 April 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**80,371**

Note 15.3 Property, plant and equipment financing - 2018/19

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019	£000	£000	£000	£000	£000	£000	£000	
Owned - purchased	7,140	45,511	1,612	2,861	7	2,512	654	**60,297**
Finance leased	-	1,448	-	-	-	286	-	**1,734**
Owned - donated	-	1,186	-	98	-	-	-	**1,284**
NBV total at 31 March 2019	**7,140**	**48,145**	**1,612**	**2,959**	**7**	**2,798**	**654**	**63,315**

Note 15.4 Property, plant and equipment financing - 2017/18

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018	£000	£000	£000	£000	£000	£000	£000	
Owned - purchased	6,565	41,686	3,126	2,635	41	2,193	927	**57,173**
Finance leased	-	-	-	-	-	347	-	**347**
Owned - donated	-	1,022	-	167	-	-	-	**1,189**
NBV total at 31 March 2018	**6,565**	**42,708**	**3,126**	**2,802**	**41**	**2,540**	**927**	**58,709**

Note 16 Donations of property, plant and equipment

During the year Stroud League of Friends donated assets for Cashes Green Ward at Stroud General Hospital for the value of £340k.

Note 17 Revaluations of property, plant and equipment

A desktop valuation has been performed by the District Valuer's office on land and specialised buildings owned by the Trust with an effective date of 31 March 2019.

All land and specialised buildings continue to be valued on an equivalent modern asset basis as in previous years. The total revaluation in the year was an increase of £3,184k (land £575k and buildings £2,609k) of which £885k expense was taken to the operating expense and benefit of £4,069 taken to revaluation reserves.

The last full valuation was the Modern Equivalent Asset model which was carried out as at 1st April 2017.

Note 18 Analysis of charitable fund reserves

Gloucestershire Care Services NHS Trust Charities has been consolidated into the Trusts accounts.

	2019	2018
	£000	£000
Unrestricted funds:		
Unrestricted income funds	43	38
Restricted funds:		
Other restricted income funds	153	158
	196	**196**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 19 Inventories

	Group		Trust	
	2019	2018	2019	2018
	£000	£000	£000	£000
Consumables	288	228	288	228
Total inventories	**288**	**228**	**288**	**228**

Note 20.1 Receivables

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Contract receivables*	8,315		8,315	
Trade receivables*		3,095		3,095
Accrued income*		3,357		3,357
Allowance for impaired contract receivables / assets*	(541)		(541)	
Allowance for other impaired receivables	-	(695)	-	(695)
Prepayments (non-PFI)	795	759	795	759
PDC dividend receivable	-	20	-	20
VAT receivable	209	187	209	187
Other receivables	-	33	-	33
NHS charitable funds: trade and other receivables	15	6	-	-
Total current receivables	**8,793**	**6,762**	**8,778**	**6,756**
Of which receivable from NHS and DHSC group bodies:				
Current	5,800	4,817	5,800	4,817

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.2 Allowances for credit losses - 2018/19

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	(695)	(695)
Changes in existing allowances	101	101
Utilisation of allowances (write offs)	53	53
Allowances as at 31 Mar 2019	**(541)**	**(541)**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April 2018	**12,412**	**8,381**	**12,354**	**8,280**
Net change in year	5,471	4,031	5,483	4,074
At 31 March 2019	**17,883**	**12,412**	**17,837**	**12,354**
Broken down into:				
Cash at commercial banks and in hand	2	2	2	2
Cash with the Government Banking Service	17,881	12,410	17,835	12,352
Total cash and cash equivalents as in SoFP	**17,883**	**12,412**	**17,837**	**12,354**
Total cash and cash equivalents as in SoCF	**17,883**	**12,412**	**17,837**	**12,354**

Note 22 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	2,500	1,203	2,500	1,203
Capital payables	1,454	1,533	1,454	1,533
Accruals	4,375	4,358	4,375	4,358
Social security costs	840	793	840	793
Other taxes payable	573	530	573	530
PDC dividend payable	75	-	75	-
Other payables	1,155	1,128	1,155	1,128
NHS charitable funds: trade and other payables	15	18	-	-
Total current trade and other payables	**10,987**	**9,563**	**10,972**	**9,545**
Of which payables from NHS and DHSC group bodies:				
Current	1,985	1,104	1,985	1,104

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23 Other liabilities

	Group		Trust	
	2019 £000	2018 £000	2019 £000	2018 £000
Current				
Deferred income: contract liabilities	389	123	389	123
Total other current liabilities	**389**	**123**	**389**	**123**

Note 24 Borrowings

	Group		Trust	
	2019 £000	2018 £000	2019 £000	2018 £000
Current				
Obligations under finance leases	76	148	76	148
Total current borrowings	**76**	**148**	**76**	**148**
Non-current				
Obligations under finance leases	1,593	221	1,593	221
Total non-current borrowings	**1,593**	**221**	**1,593**	**221**

During the year a new finance lease was entered into for the Independent Living Centre in Cheltenham.

Note 24.1 Reconciliation of liabilities arising from financing activities

Group	Leases	Total
	£000	£000
Carrying value at 1 April 2018	369	369
Cash movements:		
Financing cash flows - payments and receipts of principal	(147)	(147)
Non-cash movements:		
Additions	1,447	1,447
Carrying value at 31 March 2019	**1,669**	**1,669**

Trust	Leases	Total
	£000	£000
Carrying value at 1 April 2018	369	369
Cash movements:		-
Financing cash flows - payments and receipts of principal	(147)	(147)
Non-cash movements:		
Additions	1,447	1,447
Carrying value at 31 March 2019	**1,669**	**1,669**

Note 25 Finance leases

Gloucestershire Care Services NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Group		Trust	
	2019	2018	2019	2018
	£000	£000	£000	£000
Gross lease liabilities	**1,803**	**369**	**1,803**	**369**
of which liabilities are due:				
- not later than one year;	210	148	210	148
- later than one year and not later than five years;	328	221	328	221
- later than five years.	1,265	-	1,265	-
Finance charges allocated to future periods	(134)	-	(134)	-
Net lease liabilities	**1,669**	**369**	**1,669**	**369**
of which payable:				
- not later than one year;	76	148	76	148
- later than one year and not later than five years;	328	221	328	221
- later than five years.	1,265	-	1,265	-

There are 2 significant finances lease commitments for the Trust which are as follows:-

Laptop Computers used by clinical staff - this is a 3 year commitment ending in September 2020
Indpendent Living Centre Building - this is a 25 year lease ending in March 2043

Note 26.1 Provisions for liabilities and charges analysis (Group)

Group	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2018	**8**	**152**	**160**
Arising during the year	**17**	346	**363**
Utilised during the year	-	(95)	**(95)**
Reversed unused	-	(57)	**(57)**
At 31 March 2019	**25**	**346**	**371**
Expected timing of cash flows:			
- not later than one year;	25	346	**371**
Total	**25**	**346**	**371**

The provisions of £371k relates to £25k legal claims with NHS Resolution and £346k VAT with HMRC.

Note 26.2 Provisions for liabilities and charges analysis (Trust)

Trust	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2018	**8**	**152**	**160**
Arising during the year	17	346	**363**
Utilised during the year	-	(95)	**(95)**
Reversed unused	-	(57)	**(57)**
At 31 March 2019	**25**	**346**	**371**
Expected timing of cash flows:			
- not later than one year;	25	346	
Total	**25**	**346**	**371**

The provisions of £371k relates to £25k legal claims with NHS Resolution and £346k VAT with HMRC.

Note 27 Clinical negligence liabilities

At 31 March 2019, £796k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Care Services NHS Trust (31 March 2018: £1,047k).

Note 28 Defined benefit pension schemes

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Local Government Pension Scheme (LGPS)

As part of the S75 Integrated Services arrangements, the Trust employs staff who were TUPEd from Gloucestershire County Council. As part of the TUPE transfer, former local authority staff could elect to remain in the LGPS. The LGPS is a defined benefit statutory scheme administered by the County Council in accordance with the LGPS (Benefits, Membership and Contributions) Regulations 2007; the LGPS (Administration) Regulations 2008 and the LGPS (Transitional Provisions) Regulations 2008. It is contracted out of the State Second Pension.

During the financial period 1 April 2018 to 31 March 2019, the Trust's pension contributions totalled £63k and employees' contributions totalled £17k.

Key Assumptions in actuarial valuation of assets and liabilities	**31-Mar-19**	**31-Mar-18**
	%	%
Pension Increase Rate	2.50%	2.40%
Salary Increase Rate	2.80%	2.70%
Discount Rate	2.40%	2.60%

The fair value of employer assets of the whole fund as at 31 March 2019 is as shown below:

	31-Mar-19		**31-Mar-18**	
Assets	**£000s**	%	**£000s**	%
Equity Securities	0	0%	1,447	18%
Debt Securities	1,138	14%	1,061	13%
Private Equity	18	0%	20	0%
Real Estate	751	9%	553	7%
Investment Funds & Unit Trusts	6,201	75%	4,722	60%
Derivatives	0	0%	6	0%
Cash and Cash Equivalents	152	2%	115	2%
	8,260	100%	7,924	100%

The details of the Trust's share of assets and the net position as included in the accounts are as follows:

	Assets	**Obligations**	**Net Asset / (Liability)**
	£000s	**£000s**	**£000s**
Fair Value of employer assets	7,924	-	7,924
Present value of funded liabilities	-	(7,661)	(7,661)
Opening position at 31 March 2018	**7,924**	**(7,661)**	**263**
Current service cost	-	(108)	(108)
Net interest			
Interest on plan assets	*205*	-	*205*
Interest cost on defined benefit obligation	-	(198)	*(198)*
Total net interest	205	(198)	7
Total defined benefit cost recognised in SOCI	*205*	(306)	(101)
Cashflow			
Participants contributions	17	(17)	-
Employer contributions	63		63
Benefits paid	(186)	186	-
Expected closing position	**8,023**	**(7,798)**	**225**
Remeasurements			
Change in demographic assumptions			
Change in financial assumptions	-	(402)	(402)
Other experience			
Returns on assets excluding amounts included in net interest	237	-	237
Remeasurements recognised in other comprehensive income	**237**	**(402)**	**(165)**
Fair value of employer assets	8,260	-	8,260
Present Value of funded liabilities	-	(8,200)	(8,200)
Closing position at 31 March 2019	**8,260**	**(8,200)**	**60**
In Year Movement	**(336)**	**539**	**203**

The in year decrease in attributable net assets has not been reflected in the accounts of the Trust. The Trust elected at 31/3/16 not to show the the value of any attributable surplus pension scheme assets on its balance sheet as there is no scenario where these would become the property of the Trust.

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with the local Clincal Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies, to which the reporting standards mainly apply.

The Trust's treasury management operations are carried out by the Finance Department, within parameters formally defined within the Trust's Standing Financial Instructions and policies agreed by a committee of the Board. Trust treasury activity is subject to review by the Trust's internal auditor.

Currency risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the U.K. and sterling based. The Trust has no oversees operations. The Trust therefore has low exposure to currency fluctuations.

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies. The Trust has low exposure credit risk. The maximum exposures at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred uder contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	7,333	**7,333**
Cash and cash equivalents	17,837	**17,837**
Consolidated NHS Charitable fund financial assets	61	**61**
Total at 31 March 2019	**25,231**	**25,231**

Group	Loans and receivables	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	3,616	**3,616**
Cash and cash equivalents	12,354	**12,354**
Consolidated NHS Charitable fund financial assets	64	**64**
Total at 31 March 2018	**16,034**	**16,034**

Trust	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	7,333	**7,333**
Cash and cash equivalents	17,837	**17,837**
Total at 31 March 2019	**25,170**	**25,170**

Trust	Loans and receivables	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	3,616	**3,616**
Cash and cash equivalents	12,354	**12,354**
Total at 31 March 2018	**15,970**	**15,970**

Note 29.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Obligations under finance leases	1,669	**1,669**
Trade and other payables excluding non financial liabilities	9,484	**9,484**
Consolidated NHS charitable fund financial liabilities	15	**15**
Total at 31 March 2019	**11,168**	**11,168**

Group	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Obligations under finance leases	369	**369**
Trade and other payables excluding non financial liabilities	8,716	**8,716**
Consolidated NHS charitable fund financial liabilities	18	**18**
Total at 31 March 2018	**9,103**	**9,103**

Trust	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Obligations under finance leases	1,669	**1,669**
Trade and other payables excluding non financial liabilities	9,484	**9,484**
Total at 31 March 2019	**11,153**	**11,153**

Trust	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Obligations under finance leases	369	**369**
Trade and other payables excluding non financial liabilities	8,716	**8,716**
Total at 31 March 2018	**9,085**	**9,085**

Note 29.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	9,575	8,882	9,560	8,864
In more than one year but not more than two years	328	148	328	148
In more than two years but not more than five years	1,265	73	1,265	73
Total	**11,168**	**9,103**	**11,153**	**9,085**

Note 30 Losses and special payments

Group and Trust	2018/19 Total number of cases Number	2018/19 Total value of cases £000	2017/18 Total number of cases Number	2017/18 Total value of cases £000
Special payments				
Ex-gratia payments	-	-	3	3
Special severance payments	-	-	-	-
Total special payments	-	-	**3**	**3**
Total losses and special payments	-	-	**3**	**3**

Note 31.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Reassessment of allowances for credit losses under the expected loss model resulted in an immaterial decrease in the carrying value of receivables for which no adjustment to the opening balance was made.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £91k.

Note 31.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 32 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff or parties related to any of them, has undertaken any material transactions with the Trust.

The Trust Chief Executive Paul Roberts, is also Chief Executive of 2Gether NHS Foundation Trust.
The Trust Chair Ingrid Barker, is also Chair of 2Gether NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

As at 31 March 2019	Income	Expenditure	Receivables	Payables
Entity	£000	£000	£000	£000
NHS Gloucestershire CCG	93,964	29	741	10
Gloucestershire Hospitals NHS Foundation Trust	5,856	3,720	1,650	1,443
NHS England (includes PSF)	10,596	52	2,789	37
Department of Health & Social Care	1,449	-	-	-
Gloucestershire County Council	1,898	763	1,201	-
NHS Resolution	-	296	-	-
HM Revenue and Customs	-	5,775	209	1,413
NHS Pensions Authority	-	8,471	-	1,124

As at 31 March 2018	Income	Expenditure	Receivables	Payables
Entity	£000	£000	£000	£000
NHS Gloucestershire CCG	92,849	-	184	-
Gloucestershire Hospitals NHS Foundation Trust	5,816	4,442	80	514
NHS England	10,200	4	3,541	-
Gloucestershire County Council	2,071	1,106	704	148
NHS Resolution	-	367	-	-
HM Revenue and Customs	-	5,265	186	1,323
NHS Pensions Authority	-	8,249	-	1,122

The Trust has also received revenue and capital payments from its' charitable funds, of which all Trustees are also members of the Trust board.

Note 33 Prior period adjustments

No events have occurred since the balance sheet date that require adjustment or disclosure.

Note 34 Better Payment Practice code

Non-NHS Payables	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Total non-NHS trade invoices paid in the year	21,009	24,965	20,746	25,375
Total non-NHS trade invoices paid within target	16,442	19,287	10,242	9,585
Percentage of non-NHS trade invoices paid within target	78.3%	77.3%	49.4%	37.8%
NHS Payables				
Total NHS trade invoices paid in the year	339	2,284	377	1,797
Total NHS trade invoices paid within target	273	1,634	105	425
Percentage of NHS trade invoices paid within target	80.5%	71.5%	27.9%	23.7%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 35 External financing

The Trust is given an external financing limit against which it is permitted to underspend

	2018/19 £000	2017/18 £000
Cash flow financing	(5,336)	(4,148)
External financing requirement	**(5,336)**	**(4,148)**
External financing limit (EFL)	(1,459)	(802)
Under spend against EFL	**3,877**	**3,346**

Note 36 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	5,721	3,335
Less: Disposals	(56)	-
Less: Donated and granted capital additions	(340)	-
Charge against Capital Resource Limit	**5,325**	**3,335**
Capital Resource Limit	5,335	3,400
Under spend against CRL	**10**	**65**

Note 37 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus (control total basis)	5,069
Breakeven duty financial performance surplus	**5,069**

Note 38 Breakeven duty rolling assessment

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	2,006	1,508	2,501	2,309	5,563	5,069
Breakeven duty cumulative postion	2,006	3,514	6,015	8,324	13,887	18,956
Operating income	108,980	114,111	113,905	112,624	114,545	118,622
Cumulative breakeven position as a percentage of operating income	1.8%	3.1%	5.3%	7.4%	12.1%	16.0%

Please see SOCI for a breakdown of the surplus position

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF GLOUCESTERSHIRE CARE SERVICES NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Gloucestershire Care Services NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter- going concern basis of preparation

We draw attention to the disclosure made in note 1.2 to the financial statements which explains that whilst the Trust is not a going concern due to its expected acquisition on 30 September 2019.The financial statements of the Trust have been prepared on the going concern basis because its services will continue to be provided by the acquiring public sector body. Our opinion is not modified in respect of this matter.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 57, the directors are responsible for: the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 56 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 56, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Gloucestershire Care Services NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Gloucestershire Care Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Rees Batley

Rees Batley
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
66 Queens Square, Bristol, BS1 4BE

24 May 2019

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Glossary

Abbreviations used in this report

ACP	Advance Care Practitioner
AGS	Annual Governance Statement
AHP	Allied Health Professional
AIS	Accessible Information Standard
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BIRTIE	The name of a data analysis tool used by the Trust
BME	Black and Minority Ethnic
Breeam	Building Research Establishment Environmental Assessment Method
C-Difficile	Clostridioides difficile
CETV	Cash Equivalent Transfer Value
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CQC	Care Quality Commission
CSR	Corporate Social Responsibility
DoH	Department of Health and Social Care
EAA	European Economic Area
EDS2	Equality Delivery System
ENP	Emergency Nurse Practitioner
ESD	Early Supported Discharge
ESR	Electronic Staff Record
EU	European Union
FFT	Friends and Family Test
GCC	Gloucestershire County Council
GCCG	Gloucestershire Clinical Commissioning Group
GCS	Gloucestershire Care Services NHS Trust
GDPR	General Data Protection Regulation
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GOAM	General and Old Age Medicine
GP	General Practice
HEE	Health Education England
HIV	Human Immunodeficiency Viruses
HM Treasury	Her Majesty's Treasury
HPV	Human papillomavirus
HR	Human Resources
H&SC	Health and Social Care
ICS	Integrated Care Systems
ICT	Integrated Care Team
IIP	Investors in People
IT	Information Technology
IV	Intravenous Therapy
LED	Light-emitting diode

Glossary

Abbreviations used in this report

LWAB	Local Workforce Action Board
MIlU	Minor Injury and Illness Units
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculo-skeletal
MSKAPS	Musculo-skeletal Advanced Practitioners Services
NHS	National Health Service
NHSFT	National Health Service Foundation Trust
NHSI	NHS Improvement
NMC	Nursing and Midwifery Council
OD	Organisational Development
Org	Organisation
OT	Occupational Therapy or Occupational Therapist
PME	Programme Management Executive
QEIA	Quality Equality Impact Assessments
RGN	Registered General Nurse
R&R	Recruitment and Retention
RRP	Recruitment and Retention Plan
SILG	Strategic Intent Leadership Group
SLT	Speech and Language Therapy
Snr	Senior
SPCA	Single Point of Clinical Access
TNA	Trainee Nursing Associate
UK	United Kingdom
VSM	Very Senior Manager(s)
VTE	Venous Thomboembelism
WDES	World Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent

Caring | Open | Responsible | Effective

NHS
Gloucestershire
Care Services
NHS Trust

Gloucestershire Care Services NHS Trust
Edward Jenner Court
1010 Pioneer Avenue
Gloucestershire Business Park
Brockworth
Gloucester GL3 4AW

0300 421 8100
contactus@glos-care.nhs.uk
www.glos-care.nhs.uk